Florida Network for Youth and Family Services
Compliance Monitoring Report for

Youth and Family Advocates, Inc.
RAP HOUSE

7522 Plathe Road
New Port Richey, FL 34653

February 5-6, 2025

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 Advocates, Inc. (RAP HOUSE) for the FY 2024-2025 at its program office located at 7522 Plathe Road, New Port Richey, Florida 34653. 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 Advocates, Inc. (RAP HOUSE) is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective from July 2024 through June 30, 2025.

The compliance monitoring review was conducted by Andrea Haugabook, Consultant for Forefront LLC. Agency representatives from Youth and Family Advocates, Inc. (RAP HOUSE) present for the entrance interview were: Wayne Delapenha, Training Specialist, Michelle Almand, Quality Improvement Prevention, Amanda Kilian Senior Vice-President Quality, Susan Eby Chief Operating Officer, Roderick Jefferson, Senior Director, Sonya Kalomeres, Program Manager SNAP, Saleeta Ewing, Residential Supervisor, Jasmine Crayton, Program Director, Kelly Scott, Program Director, Rick Manuel Vice-President of Operations. The last onsite QI visit was conducted on March 27-28, 2024.

In general, the Reviewer found that Youth and Family Advocates, Inc. (RAP HOUSE) is in compliance with specific contract requirements. **Youth and Family Advocates, Inc. (RAP HOUSE) received an overall compliance rating of 100% for achieving full compliance with 12 indicators** of the CINS/FINS Monitoring Tool. 1)There were no recommendations 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 02-05-06-2025

Agency Name: Youth and Family Advocates, Inc.	Monitor Name: Andrea Haugabook, Lead Reviewer
Contract Type : CINS/FINS	Region/Office: 7524 Plathe Road, New Port Richey, FL 34653
Service Description: Comprehensive Onsite Compliance Monitoring	Site Visit Date(s): February 5-6, 2025

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 a total of eight certified peer reviewers. There are two reviewers designated for this location: Sabrina Saliba and Saleeta Ewing. Other agency peers are used as back-up in the event the site-specific peers are not able to complete a review. Roderick Jefferson, Jovia Dukes, Shelly Gress, Michelle Almand, Kelley Scott and Felicia Jones are all certified peer reviewers. The agency has met its contractual requirement for participation in QI reviews for the 24-25 fiscal year.	
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 (09/30/2024-09/30-2025) $200,000, Department of Health (10/01/2024-09/30/2025) $49,911, Family Support Services (07/01/2024-12/31/2025 $307.57/ bed day, and United Way of Pasco (07/01/2024-06/30/2025) $36,000.	
Limits of Coverage	☐	☐	☒	☐	☐	Documentation of certificate of insurance for 07/0/2024 - 07/01/2025 from	

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a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						insurance agents, March and McLeannan, was reviewed. Benchmark Insurance is the company listed as providing coverage. The certificate listed the following minimum 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 as payee.	
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.	

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Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Acceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	The agency has written employee and fiscal policies that are in compliance with GAAP and provide sound internal 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 – December 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. An 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,	

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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:
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation and documentation provided contained 2 signatures. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Bank statements and reconciliations from July 2024 through December 2024 were reviewed. Interview with the vice-president of finance reports that Accountant 1 performs the 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	

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						were observed for each pay period from July 2024 through January 2025.	
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 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 spending plans are conducted with the program directors and operations. These 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	☐	☐	☒	☐	☐	An audit report prepared by Rivero, Gordimer and Company, PA., on December 30, 2024, was reviewed. The audit period reflected in this report was through June 30, 2024. The report stated, " In our opinion, the combined financial statements present fairly, in all material respects, the financial	

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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:
and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Can obtain from FNYFS**						position of the organization as of June 30, 2024, and all the changes in its net assets and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.	
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 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	

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	Explain Rating						
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:**
						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 Advocates – RAP House has met the requirements for the CINS/FINS contract as a result of full compliance with 12 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the fourteen indicators were not applicable because the program has no inventory purchased with funds from the Florida Network of Youth and Family Services and the program does not have any external corrective action items from other funding sources. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no recommendations or corrective actions 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 meets the standard described in the report findings.

SUMMARY OF CORRECTIVE ACTIONS or RECOMMENDATIONS

Corrective Action (1)
None

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 Advocates - Rap House
CINS/FINS Program

Date: February 5-6, 2025

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	Limited
1.04 Training Requirements	Limited
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

Percent of Indicators rated Satisfactory: 71.43 %
Percent of Indicators rated Limited: 28.57 %
Percent of Indicators rated Failed: 0 %

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Special Populations	Satisfactory
2.09 Stop Now and Plan (SNAP)	Satisfactory

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

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	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: 85.71 %
Percent of Indicators rated Limited: 14.29 %
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	Limited
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: 20 %
Percent of Indicators rated Failed: 0 %

Overall Rating Summary

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

Rating Definitions

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

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

Reviewers

Members

Andrea Haugabook - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Cheryl Francis and Sandi Thompson – Regional Monitor, Department of Juvenile Justice
Duane Gross – Children's Home Society
LaToya Robinson – CDS
Linda Sessions – Hillsborough County Children's Services

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

X	Chief Executive Officer	X	Case Manager		Nurse – Full time
	Chief Financial Officer		Counselor Non-Licensed	X	Nurse – Part time
X	Chief Operating Officer		Advocate	1	# Case Managers
X	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	2	# Other: QI Coordinator, Training Coordinator
X	Counselor Licensed	X	Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	3	# Health Records
X	Logbooks		Key Control Log	6	# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log	11	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	6	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	7	# 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

X	Intake	X	Posting of Abuse Hotline	X	Staff Supervision of Youth
X	Program Activities	X	Tool Inventory and Storage	X	Facility and Grounds
	Recreation	X	Toxic Item Inventory & Storage	X	First Aid Kit(s)
X	Searches		Discharge		Group
X	Security Video Tapes		Treatment Team Meetings		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

5	# of Youth	18	# 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 Advocates (YFA) - RAP House is located at 7524 Plathe Road, New Port Richey, FL 34653. The program was founded as Youth and Family Alternatives, Inc. in 1970. YFA was initially created to serve as a 'drop-in center' in Pasco County for local children in crisis due to child abuse and neglect, drug use, truancy, runaways, and teen pregnancy. The program provides several services in the areas of Prevention, Child Welfare Case Management, Foster Care and Adoptions, Youth Shelter, and Supportive Housing. YFA - RAP House serves the following Florida Counties: Citrus, Hardee, Hernando, Highlands, Pasco, Polk, and Sumter.

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

Standard 2: There are nine indicators for Standard 2.
Indicator 2.01 Screening and Intake was rated **Satisfactory with Exception.**
Indicator 2.02 Needs Assessment was rated **Satisfactory.**
Indicator 2.03 Case/Service Plan was rated **Satisfactory**.
Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory.**
Indicator 2.05 Counseling Services was rated **Satisfactory.**
Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory.**
Indicator 2.07 Youth Records was rated **Satisfactory**.
Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory**.
Indicator 2.09 Stop Now and Plan (SNAP) was rated **Satisfactory**.

Standard 3: There are seven indicators for Standard 3.
Indicator 3.01 Shelter Environment was rated **Satisfactory with Exception.**
Indicator 3.02 Program Orientation was rated **Satisfactory.**
Indicator 3.03 Youth Room Assignment was rated **Satisfactory.**
Indicator 3.04 Log Books was rated **Limited.**
Indicator 3.05 Behavior Management Strategies was rated **Satisfactory.**
Indicator 3.06 Staffing and Youth Supervision was rated **Satisfactory.**
Indicator 3.07 Video Surveillance System was rated **Satisfactory 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 **Limited.**
Indicator 4.04 Medical/Mental Health Alert Process was rated **Satisfactory.**
Indicator 4.05 Episodic/Emergency Care was rated **Satisfactory**.

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

STANDARD 1

Indicator 1.03 Incident Reports was rated limited due to two of the 40 CCC reportable events were not reported in the two hour timeframe required. Fourteen of forty CCC incidents were not able to be located in the program logbooks.

Indicator 1.04 Training Requirements was rated limited due to no evidence of any supporting documentation in the training files for all required new hire pre-service training listed on the employees' training log.

One staff did not complete the civil rights training timely. The hire date was 4/8/2024 and the training was completed on 7/23/2024.

One employee did not complete the required training within the 90 day timeframe, the hire date is 4/8/2024. The following trainings were completed after July 7, 2024; DJJ Skill Pro #168 - Child Abuse: Recognition, Reporting and Prevention, completed on 7/16/2024, DJJ Skill Pro Course #1484 - Civil Rights & Federal Funds (United States Department of Justice), completed on 7/23/2024, DJJ Skill Pro- #112 Equal Employment Opportunity, completed on 7/22/2024, DJJ Skill Pro - #316 Human Trafficking Intervention for Direct Care Staff, completed on 7/16/2024, DJJ Skill Pro - #45 Information Security Awareness, completed on 7/16/2024, DJJ Skill Pro Course #1549, Prison Rape Elimination Act (PREA) - Part 1, completed on 7/11/2024, DJJ Skill Pro Course #1546 Prison Rape Elimination Act (PREA) - Part 2, completed on 7/15/2024, DJJ Skill Pro- #111 Sexual Harassment, completed on 7/15/2024 “DJJ Skill Pro #125 - Trauma Responsive Practices, completed on 7/19/2024.

STANDARD 3

Indicator 3.04 Incident Reports was rated limited due to a review of a sample of five random weeks of logbook entries (August - December) lacked documentation to evidence direct care staff upon starting their shift(s) reviewed the logbook for the previous two shifts with their signature at the time of entry.

STANDARD 4

Indicator 4.03 Medications was rated limited due to ten dates observed in CCC incident reports where staff provided youth with medications outside the one hour of the scheduled time of delivery as ordered by the medication.

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 policy RGC 1.01 Background screening of Employees/ Volunteers/ Interns/ Contracted Providers last reviewed by the COO 10/13/2023.	
All positions providing direct services to youth have successfully passed the pre-employment suitability assessment on the initial attempt prior to an offer of employment.	**Exception**	Nine of ten new hire staff in positions providing direct services to youth have successfully passed the pre-employment suitability assessment on the initial attempt prior to an offer of employment.	One of ten new hire staff in positions providing direct services to youth did not pass the pre-employment suitability assessment prior to an offer of employment. The initial suitability assessment was taken and passed after the employee's hire/ start date.
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**	There was no evidence of any new hire staff needing to retake the suitability assessment.	
Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	**No eligible items for review**	There were no new hire employees who have had a break in service for 18 months or more.	
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors. *(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**	Nine of nine employee files reviewed contained evidence of completion of a background screening prior to hire/ start date.	
Five-year re-screening is completed every 5 years from the date of the last screening for all applicable employees and volunteers.	**Compliance**	Five-year re-screening is completed every 5 years from the date of the last screening for one of one applicable employee file reviewed.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The program provided evidence of a completed Annual Affidavit of Compliance with Level 2 Screening Standards was emailed to BSU before January 31st.	

Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Proof of E-Verify for all ten new employees obtained from the Department of Homeland Security was present in the employee files reviewed.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**YES** If NO, explain here: The agency has a policy RGC 1.02 Provision of an Abuse Free Environment last reviewed by the COO 10/13/2023.	
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	Documentation of a code of conduct policy was observed in the program's policy and staff are made aware of the code of conduct at orientation.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The agency has a process in place for reporting and documenting child abuse hotline calls. The following is an observation of documented child abuse hotline calls: July 2024 - one call documented, September 2024 - one call documented, October 2024 - five calls documented, November 2024 - three calls documented, and December 2024, January 2025, February 2025 each had one call documented respectively.	
Youth were informed of the Abuse and Contact Number	**Compliance**	Documentation in each youth record reviewed showed evidence the youth are informed of the abuse hotline contact number. Additionally, the number is posted conspicuously throughout the facility.	
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 program's practice reflects an accessible and responsive grievance process. Youth are free to file grievances or provide feedback. The supervisor addresses all grievances unless it is towards themselves.	
Shelter only: Grievances are maintained on file at minimum for 1 year.	**Compliance**	Observations of grievances were maintained for a minimum of one year.	
Shelter only: There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Compliance**	There is a locked grievance box observed in the youth's common area accompanied by forms to complete in the event a youth desires to complete a grievance.	

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**	Log book entries reviewed over the past six months showed proof of the grievance box being checked consistently each weekday.	
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**	All grievances are resolved within 72 hours as documented.	
Additional Comments: **There are no additional comments for this indicator.**			
1.03: Incident Reporting			**Limited**
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 RGC 1.03 RM760 Incident Reporting last reviewed by the COO 10/13/2023.	
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**	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 in 38 reportable events.	Two of the 40 CCC reportable events were not reported in the two hour timeframe required.
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	An interview with the Program Director indicated the program completes follow up communication and tasks as required by the CCC.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	All internal incidents reviewed were documented on internal incident reporting forms including all CCC reportable incidents.	
Incidents are documented in the program logs and on incident reporting forms	**Exception**	A review of the program logbooks for the past six months and CCC reports from July 2024 to January 15, 2025, there were observations of twenty-six incidents recorded in the program's logs. The program documented incidents on the reporting forms as required.	Fourteen of forty CCC incidents were not able to be located in the program logbooks.
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	All incident reports were reviewed and signed by the program supervisor. The number of total incidents reported by type were as follows: Program Disruption- 16, Abscond/Escape-0, Medical-18, Mental Health/Substance Abuse-3, Complaints Against Staff-3, and Youth Behavior-0 Observation of high risk level incidents: Three incidents of complaints against staff (202406785, 202407008, and 202405112) involved inappropriate behavior with youth and staff arrests.	
Additional Comments: **There are no additional comments for this indicator.**			

1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The agency has a policy RGC 1.04, Training, Last reviewed/approved 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.	**Exception**	Three files were reviewed for first-year direct care staff training; case manager, youth development specialist and counselor. Each training file included a training log that captured the information required for new hire pre-service.	All three staff files reviewed lacked completion of required pre-service training. The reviewer did not receive completion dates nor supporting documentation as evidence of completion for training indicated on the pre-service training logs. The training coordinator and QI staff were interviewed and informed this reviewer of a new QI process that was implemented to produce evidence to ensure trainings are completed and timely in the future. One staff was missing all nine of the applicable pre-service training for their position, the other two staff were both missing evidence of the 11 required pre-service training for their positions.
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Exception**	Three files were reviewed for first year direct care staff training; Two staff completed the training within the 30 day timeframe, hire date 3/11/2024, training completed on 3/13/2024 and the other hire date was 7/17/2023, training completed on 7/19/2023.	One staff of the three did not complete the Civil Rights training timely. The hire date was 4/8/2024 and the training was completed on 7/23/2024.
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 files were reviewed for the first year direct care staff training, two employees are still within their first year with hire dates of 3/11/2024 and 4/8/2024 and one employee with hire date of 7/17/2023, completed 90.75 hours of training within her first year.	

All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Three files were reviewed for new hire training, two employees completed the required training within 90 days of hire. The training coordinator and QI specialist were interviewed and stated neither of the employees whose files were reviewed, enters information in Juvenile Justice Information System (JJIS) and the training was not applicable. The training specialist indicated he is in the process of working with Skill Pro to add trainings to staff transcripts that were completed during the period of the system outage.	One employee did not complete the required training within the 90 day timeframe, the hire date is 4/8/2024. The following trainings were completed after July 7, 2024; "DJJ Skill Pro #168 - Child Abuse: Recognition, Reporting and Prevention," completed on 7/16/2024, "DJJ Skill Pro Course #1484 - Civil Rights & Federal Funds (United States Department of Justice)," completed on 7/23/2024, "DJJ Skill Pro- #112 Equal Employment Opportunity," completed on 7/22/2024, "DJJ Skill Pro - #316 Human Trafficking Intervention for Direct Care Staff," completed on 7/16/2024, "DJJ Skill Pro - #45 Information Security Awareness," completed on 7/16/2024, "DJJ Skill Pro Course #1549," "Prison Rape Elimination Act (PREA) - Part 1," completed on 7/11/2024, "DJJ Skill Pro Course #1546 Prison Rape Elimination Act (PREA) - Part 2," completed on 7/15/2024, "DJJ Skill Pro- #111 Sexual Harassment," completed on 7/15/2024 "DJJ Skill Pro #125 - Trauma Responsive Practices," completed on 7/19/2024. The training coordinator and QI specialist were interviewed and advised this staff incurred late trainings due to Skill Pro being down for several months. Skill Pro provided a link for staff to complete trainings and staff were advised to capture evidence via screenshot of all completed training to post to Skill Pro transcripts later. This staff was unable to produce the evidence of initial training completed using the alternate Skill Pro link. Post-review interview with the Training Coordinator indicated that he assumed the responsibility of maintaining the CC training files in July 2024. Upon assuming those duties he checked the files for compliance and this employee did not have proof of completion of the trainings listed above. The employee was instructed to re-take the trainings.
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**	Three files were reviewed for new hire training. One staff completed the required training for medication distribution for staff without a medical license and the PYXIS training. According to the training specialist, two employees do not assist with medication, however one did complete the required training for medication distribution for staff without a medical license.	

Staff that are Utilizing NETMIS			
Any staff that is utilizing NETMIS has evidence of completing NetMIS Training in their training file.	**Compliance**	Three files were reviewed for the new hire training, the training coordinator was interviewed who indicated one of the three files reviewed, one employee enters in the NETMIS system, which her training was completed.	
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).*	**No eligible items for review**	Three files were reviewed for the new hire training, the training coordinator was interviewed who indicated neither of the employees are involved in the CINS petition process.	
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 were applicable as non-licensed mental health clinical shelter staff.	
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 in-service files reviewed contained evidence of required annual or two year mandatory refresher Florida Network, SkillPro, or other job-related trainings within the required timeframe.	
Community Counseling Direct Care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.	**Exception**	Two of three files reviewed completed the required 24 hours of mandatory trainings within the agency's training year.	One employee's file reviewed has a total of 23 hours for the previous fiscal year instead of the required 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).*	**No eligible items for review**	Three files reviewed, All three files in the sample were community counseling staff.	
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**	Six files were reviewed and each training file included a training plan that captured the required information for pre-service and in-service.	
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Compliance**	The QI specialist was interviewed and indicated the agency has a training coordinator responsible to manage and track all employees individual training files. The training coordinator is responsible for reviewing the staff files to ensure compliance.	

The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	Six files were reviewed and each training file included a training log that captured the required information.	
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 files were reviewed, one staff completed the Naloxone training. The remaining staff have until 7/1/2025 to complete the training.	
Additional Comments: **There are no additional comments for this indicator.**			
1.05 - Analyzing and Reporting Information			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**YES** If NO, explain here: The agency has a policy titled Continuous Quality Improvement Plan. The policy is not signed and dated for review.	
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**	A review of the program's continuous improvement process included: RAP Annual CQI review dated 12/10/2024, CQI worksheets dated 12/05/2024, 09/06/2024, 10/28/2024, October YFA Non-Residential (CINS/FINS) Scoring Tool, and the Quarterly Pasco Review dated 01/15/2025. Mock peer reviews (07/03/2024) occur twice a year and results are reported back to the Program Director. Weekly CQI Reviews cover Medication, Logbooks, Facility and Grounds, Fire Drills, Grievance Box, Kitchen, Fire Extinguishers, and Suicide Client Files. A review of shelter meetings by the QI Program Coordinator for Prevention shows the Program Director reports the results to the staff at the monthly shelter meetings.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	The program conducts reviews of incidents, accidents and grievances as observed in the Risk Prevention and Management Team - CQI committee meeting minutes for the last two quarters 07/01/2024 and 10/14/2024. Additional documentation was observed in Quarterly Management and Data Meeting minutes dated November 21, 2024 and August 15, 2024 where a review of FY 23-24 incident report roll-ups was discussed and FY 23-24 incident report graphs were presented. These matters are also regularly discussed in monthly shelter meetings.	

The program conducts an annual review of customer satisfaction data	**Compliance**	1st Qtr. CQI Stakeholders Involvement Team - FY 2024-2025 meeting minutes dated 10/25/2024 showed a review of the FNYFS Satisfaction Survey Summary Report for both parents and youth. Customer satisfaction data is also discussed at monthly shelter meetings.	
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**	End-of-Month reports are received each month by each of the program directors and it is reviewed and presented at each of the shelter meetings. It also is sent to the COO, VP, Sr. VP of Program Development and data analytics.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The agency's standard operating procedure addresses the review of data and collection. The program's process of reviewing and improving accuracy of data entry and collection is evident various program meeting minutes.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	Observation of several different meeting minutes indicate that findings are reviewed by the board of directors. Sr. Vice President of data analytics compiles monthly data snapshots and sends it to the board of directors. There is an ongoing watchlist which includes deliverables that are monitored regularly and reports things that are performing well as well as things that are under performing.	
There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	Review of Board meeting minutes (August 22, 2024, October 24, 2024, November and December 5, 2024) show evidence of report of program performance given by the CEO. All final reports are submitted to the Board electronically by the Business Manager.	

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 addresses strengthens and weaknesses, improvements and implementations regularly across various shelter, management, CQI, management, and leadership meetings.	
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: Indicate policy number, authorized signee, date(s) of last review/revision/approval: RCG 1.06, Client Transportation, 9/15/2023, 10/12/2023	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The agency presented an approved drivers list with names of all employees who have current valid driver's licenses as evidenced through regular checks through the Florida Department of Motor Vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	All agency drivers are covered under the agency's automobile insurance and documentation of coverage was observed.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The agency's transportation policy addresses prohibiting transportation of 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.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**Compliance**	The agency's transportation policy states, 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.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency's policy states, the 3rd party is an approved volunteer, intern, agency staff, or other youth.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Compliance**	Total number of transports and total number of documented supervisor approvals prior to transport: Two (2) The agency provided their travel log which indicated two single youth transport and two supervisor approvals.	

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**	The agency provided the travel log for the past six months which indicates the single client transport. The agency's log book was reviewed and evidence of staff notes for the check ins (by phone) corresponding to both single transport events were observed.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Compliance**	The staff provided the travel log that indicates the vehicle, initials of the driver, date, time, mileage, number of passengers, purpose and location of travel.	
Additional Comments: **There are no additional comments for this indicator.**			
1.07 - Outreach Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: The agency has a policy CS580 Community Outreach and Education approved by the CEO 09/30/2022.	
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 agency has a position Outreach Coordinator which became vacant as of January 2025. The Outreach Coordinator had participated in the local DJJ board, Circuit and Council meetings as evidenced through documentation of meeting minutes, agendas and other documentation provided by the program. The Program Director has been designated to participate in these events in the interim.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	Evidence of written agreements with local community partners to include a comprehensive referral process was observed from: Pasco Juvenile Assessment Center 02/19/2024 - 09/30/2005, DJJ and DCF - Ongoing, National Safe Place - April 2008 - Ongoing, and Paso Sheriff's Office 09/07/2023 - On-going.	
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**	A total of 41 outreach events were documented in NetMIS from 07/25/2024-12/27/2024. Each event included the title, date, duration, zip code, location, description, number of people reach, modality target audience and topic.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The agency has a position Outreach Coordinator which became vacant as of January 2025. Currently the Program Director is designated to attend and conduct outreach events.	
Additional Comments: **There are no additional comments for this indicator.**			

Standard Two – Intervention and Case Management			
2.01 - Screening and Intake			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The agency has the required policy that addresses indicator 2.01, titled, RGC 2.01 - Eligibility Screening & Intake Last reviewed: 3/26/2019, approved 10/13/2023 by CEO.	
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Compliance**	Five shelter case files were reviewed, all files contained completed eligibility screening forms 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 Community Counseling case files were reviewed, all files contained eligibility forms that were completed within three business days of the screening date.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	Both Residential and Community Counseling Programs were observed as having a consistent process of screening for eligibility, and logging the information into NetMIS within 72 hours of the screening completion.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Exception**	The program has a consent for treatment document in all files which is signed by the youth and parent acknowledging receipt of their rights and responsibilities. Five residential files reviewed contained evidence of youth and parents receiving the available service options and rights and responsibilities of the youth and parents. Five of five community counseling files reviewed contained a signed consent for treatment document which includes acknowledgment of the youth and parents' rights and responsibilities. Three of five community counseling files reviewed did have an intake progress note in the file reflecting youth and parents received both available service options and rights and responsibilities in writing at intake. In interview with the Director of the Community Counseling (CC) program, this writer learned the program's practice is to present all families with a welcome packet that includes, available service options and the family's rights and responsibilities.	There was no evidence in two files indicating the family received the available service options information. During this review, the CC Director modified a document in the intake packet, to include space for the parent, and the youth, to sign, acknowledging receipt of the items mentioned above.

The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**Exception**	Five residential files reviewed contained evidence of youth and parents receiving information regarding possible actions occurring through involvement with CINS/ FINS services and the program's grievance procedures. Three of five community counseling files reviewed did have an intake progress note in the file reflecting youth and parents received the program's grievance procedure. In interview with the Director of the Community Counseling (CC) program, this writer learned the program's practice is to present all families with a welcome packet that includes possible actions occurring through involvement with CINS/FINS services and the grievance procedure.	There was no evidence in two community counseling files, that indicated families received information pertaining to possible actions occurring through involvement with CINS/FINS services and the grievance procedure. During the review, the CC Director modified a document in the intake packet to include space for the parent, youth, and counselor to sign, acknowledging receipt of the items mentioned above. In addition, she circulated the modified document and informed her team to use the revised form effective immediately.
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Compliance**	A total of five (5) Community Counseling files were reviewed, all five (5) client were screened for suicidality and correctly assessed as required. A total of five (5) Residential files were reviewed, all five (5) client were screened for suicidality and correctly assessed as required. Both programs reflect consistency in their processes.	
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The agency has a written that meets the requirements for indicator 2.02, titled RGC 2.02 - NIRVANA - No review date listed Approved date - 10/13/2023 by CEO	
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	A total of five (5) Residential case files, including open and closed files were reviewed. All five (5) cases reflected the NIRVANA being completed within 72 hours.	
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**	A total of five (5) Community Counseling case files, including open and closed files were reviewed. All five (5) cases reflected the NIRVANA being completed within 2-3 face-to-face contacts. None of the cases were open more than 6 months.	

Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	**Compliance**	All NIRVANA assessments observed contained supervisor signatures. Both Residential and Community Counseling Programs were observed as having a consistent practice of collecting supervisor signatures on the NIRVANA.	
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	**Compliance**	All five (5) Residential files reviewed contained the NIRVANA Self-Assessment, completed within 24 hours of the youth being admitted into the program.	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Compliance**	A NIRVANA Post-Assessment was completed for four (4) of the five (5) files reviewed. One file did not due to the youth being discharged unexpectedly. There was documentation that addressed the reason for the missing post-assessment.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Compliance**	None of the files selected from either program required a NIRVANA Re-Assessment.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All ten (10) files (Residential and Community Counseling) reviewed contained a hard or electronic copy of the NIRVANA Assessment.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has a policy in place titled RGC 2.03/Service Plan Development and Service Monitoring last reviewed 10/13/2023, approved by CEO.	
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	**Compliance**	All ten (10) files (Residential and Community Counseling) reviewed contained an approved case/service plan. The goals and objectives reflected information recorded on the screening and intake forms, and the NIRVANA assessment.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All ten (10) files (Residential and Community Counseling) reviewed contained a of the case/service that was completed within 7 working 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 (10) files (Residential and Community Counseling) reviewed contained a hard or electronic copy of the following documents: 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	
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Compliance**	Seven (7) of ten (10) files (Residential and Community Counseling) reviewed reflected evidence of progress/revisions by counselor and parent after 30 days. None of the cases met the six month period. One of the three remaining cases, the youth was discharged 5 days after admission. Another youth was discharged after 11 days, another after 15 days. The documentation reflected this information.	
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 titled Traditional and Intensive Case management & Service Delivery Reviewed and approved: 10/13/2024 by CEO	
Counselor/Case Manager is assigned	**Compliance**	All client files reviewed within the shelter and the community counseling program were in compliance. There was evidence in each that identified a case manager/counselor was assigned to work 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**	In all of the shelter client files reviewed, it was evident via progress notes that the counselor referred youth and family out for more intensive services. All community counseling files contained evidence of the youth being referred to services from the local school district, as explained by the program director. All files from both programs indicate supportive services to the families. The interventions demonstrated the agency coordinating all necessary services in the implementation of the treatment plan.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The Residential and Community Counseling Program Directors confirmed that the agency maintains written agreements with other community partners. An example, it was reported that the local rotary club members come to the shelter once per week to cook with and/or provide meals for the youth, as well as a local church.	
Additional Comments: **There are no additional comments for this indicator.**			
2.05 - Counseling Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: The agency has a policy titled RGC 2.05 - Community Counseling and Residential Group Care - Last reviewed: 9/15/23 Approved on 10/13/23 by CEO	
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	All client files reviewed from the shelter program contained detailed progress notes to denote continued counseling provided for the youth and the parent/guardian while in service.	
Group counseling sessions held a minimum of five days per week	**Compliance**	Evidence was provided that demonstrated group sessions are conducted as required.	

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**	Evidence was provided that demonstrated a clear record of the facilitator, the topic of the session, the continuous opportunity for the youth to participate in the discussion, and the length of time the group sessions are held.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	Group rosters were provided for review that reflected the date, time, list of youth in the class, the topic and the length of each group session was held.	
Community Counseling			
Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, the local provider's counseling office or virtually if written documentation is provided in the youth's file for reasons why it is in the best interest of the youth and family.	**Compliance**	All client files reviewed for community counseling reflected continued support for the youth and the family at a location denoted in the best interest of the youth and parent/guardian.	
Counseling Services			
There is evidence the program completes review of all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up.	**Compliance**	All client files reflect consistent evidence of review via signatures of the supervisor or clinician.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	Both programs maintained case files that were in compliance to all laws regarding confidentiality. Consent forms were present, and signed. Both Program Directors shared that files are now kept in and electronic record system titled, "Mindshare".	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	The files from both Residential and Community Counseling programs displayed a consistent practice of maintaining case notes regarding client progress.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	All Community Counseling files contained a log page that indicated that monthly case file reviews, where the supervisor, and the counselor sign, confirming that the file has been reviewed.	
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.	**Not Applicable**	There were no cases in either program reflecting use of virtual services.	
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 titled RGC 2.06 last reviewed 9/15/23/ Approved 10/13/2023 by the CEO.	
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	Three case staffing files were reviewed, one closed, two open. The signatures located on the committee recommendation form included a DJJ Representative, a local school district representative, and the CINS/FINS provider, RAP House Program, in all three files.	
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 three case staffing files also showed evidence that law enforcement and a mental health representative consistently attended the meetings. Documentation indicated that neither the State Attorney, nor others requested by the family attended the meetings.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The community counseling program director was able to provide documentation to show that there is an established Case Staffing committee. The emails reviewed reflected constant communication, and planning among the committee members.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	The program provided documentation which reflected that the Case Staffing committee meetings were scheduled for the rest of the year.	
The youth and family are provided a new or revised plan for services	**Compliance**	There is evidence of the youth and family being provided a new or revised plan for services as required.	

Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**Compliance**	The community counseling Program Director provided documentation to show that notification of the staffing is sent via email to the committee and youth/family more than 5 days prior to the case staffing for each youth.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	There were no cases indicating the need for court involvement in this sample of files.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	There were no cases indicating the need for court involvement in this sample of files.	
Additional Comments: **There are no additional comments for this indicator.**			
2.07 - Youth Records			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The agency has a policy RGC 2.07 Last reviewed 9/15/2023 10/13/2023 by the CEO.	
All records are clearly marked 'confidential'.	**Compliance**	The community counseling Program Director explained that community counseling files are kept in the cloud, in their electronic record system titled "Mindshare". However, she printed the community counseling file information out and placed it in a temporary file, for the audit review only. The temporary folders were marked "Confidential". She informed this writer that the information will be shredded after the audit.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	The Residential Program Director confirmed, and it was verified that the client files are kept and maintained in their electronic record system, "Mindshare".	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	The community counseling Program Director confirmed, and it was verified that files are rarely transported, as she discourages her team from transporting file the client files are kept and maintained in their electronic record system, "Mindshare".	
All records are maintained in a neat and orderly manner	**Compliance**	All files are organized per the agency's file format. Each file reviewed in the sample as organized in a uniform format and all areas in the file are marked and easy to locate the required information.	

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	**Compliance**	All five residential records reviewed included a marked electronic folder where the contents of each was organized in an orderly fashion. All forms mentioned in this indicator were present. Group session sign-in forms (signed by the youth) were kept in a binder.	
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**	All five community counseling files reviewed included a table of Contents that included all of the aforementioned documents, which are required according to the indicator. However, in its paper form it is a temporary file, to be shredded when audit is completed.	
All records kept electronically, are maintained securely and can be made immediately available upon request for audit purposes.	**Compliance**	All electronic files are organized per the agency's file format. Each file reviewed in the sample are uniform, and all files are clearly marked and easy to locate. The Res Program Manager assisted in reviewing the residential files and other electronic documents.	
Records are retained for the duration of the time specified by the contract.	**Compliance**	Per the CC Program and Residential Program director, the electronic record system is built to store the electronic files for an indefinite period of time.	
Additional Comments: **There are no additional comments for this indicator.**			

2.08 - Specialized Additional Program Services			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: The agency has a written policy RGC 2.08/ Specialized Additional Program Services approved 10/13/2023.	
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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**Compliance**	The program has policies regarding staff secure which outline: 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	
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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services. No eligible items for review	
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	

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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
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”)	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
Data entry into NetMIS within (3) business days of intake and discharge	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	

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

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.	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
Service/case plan demonstrates a strength-based, trauma-informed focus	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential 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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	

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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	

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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
All data entry in NetMIS is completed within 3 business days as required.	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Satisfactory**
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 RGC 2.09 Stop Now and Plan last reviewed by the CEO 10/13/2023.	
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	**Compliance**	Five of five youth files reviewed contained evidence of screening to determine eligibility of services with the required documents: a. Florida Network Youth Screening Form b. SNAP® Brief Intake Screening Checklist	
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	**Compliance**	All five files reviewed contained 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	
The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	A NIRVANA completed an initial intake or within two sessions was present in each SNAP file reviewed.	

There is evidence of the completed the Pre - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	**Compliance**	A Pre-Child Behavior Checklist was present in each file reviewed.	
There is evidence of the completed Pre - TOPSE is completed by the caregiver and is located within the file.	**Compliance**	Completed Pre-TOPSE was present in each of the SNAP files reviewed.	
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.*)	**Compliance**	A SNAP Parent Goal Sheet and Child Way to Go Goal Sheet was present in one closed SNAP files and in progress for four open SNAP files reviewed.	
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.	**Compliance**	One of one closed SNAP files reviewed contained evidence of a completed Post-Child Behavior Checklist.	
There is evidence of the completed Post - TOPSE is completed by the caregiver and is located within the file.	**Compliance**	There was a completed Post-TOPSE in one closed SNAP file reviewed.	
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Compliance**	Documentation of a completed SNAP discharge report was observed in the one SNAP file reviewed.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Compliance**	There is evidence of a completed SNAP Boys/ Girls Child Group Evaluation Form located in the file.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Compliance**	There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the one completed SNAP file reviewed.	
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services using the Florida Network Youth Screening Form.	**Not Applicable**	The program does not conduct SNAP Clinical Groups for youth ages 12-17.	
The file contains the completed Florida Network Community Counseling Intake Form and is located within the file.	**Not Applicable**	The program does not conduct SNAP Clinical Groups for 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.	**Not Applicable**	The program does not conduct SNAP Clinical Groups for youth ages 12-17.	

The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**	The program does not conduct SNAP Clinical Groups for youth ages 12-17.	
There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**	The program does not conduct SNAP Clinical Groups for youth ages 12-17.	
There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**	The program does not conduct SNAP Clinical Groups for youth ages 12-17.	
There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**	The program does not conduct SNAP Clinical Groups for youth ages 12-17.	
All closed files contained evidence in the file a NIRVANA was completed at discharge.	**Not Applicable**	The program does not conduct SNAP Clinical Groups for 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**	A review of two completed SNAP in Schools sessions demonstrated all required weekly attendance sheets which included: youth names, teacher, and SNAP facilitator signatures.	
The program maintained evidence of a completed 'Way to Go Goal' Sheet within the file.	**Compliance**	Two SNAP in schools sessions reviewed included completed Way to Go Goal sheets in the files.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Compliance**	A completed MoCE was present in both SNAP in Schools files reviewed.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Compliance**	Each file reviewed contained completed pre and post evaluation documents.	

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.	**Compliance**	A completed SNAP in Schools Feedback Form was present in each of the files reviewed and evidence of entry into NetMIS was provided.	
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**	A Fidelity Adherence Checklist was completed and present in each file reviewed.	
Additional Comments: **There are no additional comments for this indicator.**			
Standard Three – Shelter Care			
3.01 - Shelter Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The 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.	**Compliance**	All furnishings in lobby, common areas, outside recreation area and youth dorms are in good condition. No insects were noticed during the facility tour. Total number and location of bathrooms/shower areas: There are two bathrooms on the Boys Wing and two bathrooms on the Girls Wing. One on each side is handicap accessible. All bathrooms were clean and functional. There was no evidence of graffiti on the walls, doors or window. Each of the bedrooms has a chalkboard painted wall for youth to express their themselves in writing. Lighting throughout the building is adequate for the tasks performed. The exterior of the facility are well-kept and free of debris. The grounds of the facility are well-kept and free of debris. The large dumpster area is covered and are held in a gated enclosure. Doors are secured with magnet locks and a key fob is required for entrance and exit. A typical door key can be used as well. The Agency has all of its doors secured with magnet locks, which require a key fob to enter or a traditional key can be used as well. Egress maps are posted in all the youth rooms at the door and also posted at the exit doors. Grievance boxes are at the end of each hall and in the dayroom, and one in the living room area. Abuse hotline numbers and DJJ Incident Reporting number are on a board in the hallways and in the dayroom. All interior areas were found to be clear of any contraband and free from Hazardous unauthorized metal/foreign objects.	

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**	Agency and staff vehicles on the property were found to be locked and secure. The Agency utilizes three vans for transportation of clients. Each van was equipped with the necessary safety equipment including functioning first aid kit, fire extinguisher, flashlight, glass breaker and seat belt cutter.	
Facility Inspection: All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely and Material Safety Data Sheets (MSDS) are maintained on each item (minimum 1 time per week or per agency policy). A perpetual inventory will be the primary means of maintaining a current and real-time inventory. The weekly inventory will be conducted weekly at a minimum to ensure that a perpetual inventory is being maintained consistently and accurately. If more than one location is used to store chemicals, there is an inventory wherever chemicals are stored that is current and well maintained unless previously approved by the Network.	**Compliance**	All chemicals are listed accordingly, approved for use, and are stored securely in three areas of the facility; utility closet, kitchen and laundry room. MSDS books can be found in the kitchen, utility room and laundry room and they account for each chemical used in the facility. A weekly inventory is completed on all chemicals in each of the three locations. MSDS books are in each area as well and accounts for each chemical used in the facility. The Agency maintains a perpetual inventory for all chemicals frequently used in the utility closet, kitchen and laundry room.	
Facility Inspection: Washer/dryer are operational & general area/lint collectors are clean. Agency has a current DCF Child Care License which is displayed in the facility. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket. Youth have a safe, lockable place to keep personal belongings, if requested.	**Compliance**	The Agency has three washers and three dryers that are operational and free of lint. The Agency has a current DCF Child Care License, which is displayed in the main lobby area. The DCF Date of license: April 24, 2024. Each youth has an individual bed with a clean mattress, and they are provided with appropriate bed linens that are clean and sufficient. The Agency has lockers that are at the top of each hallway that allow youth to secure any personnel items.	
Additional Facility Inspection Narrative (if applicable)			

Fire and Safety Health Hazards: a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less). c. Completes 1 mock emergency drill per shift per quarter. d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).	**Exception**	The annual facility fire inspection was conducted by the Pasco County Fire Marshall with an inspection date of 1/21/25. Fire drills were conducted on each shift as follows: **1st Shift:** 8/6/24, 9/11/24, 10/16/24, 11/6/24, 12/6/24, 12/29/24, 1/1/25 **2nd Shift:** 8/12/24, 11/9/24, 12/12/24, 1/13/25, 1/14/25 **3rd Shift:** 8/7/24, 11/8/24, 12/11/24, 1/9/25 All mock emergency drills per shift were done at a minimum of one per quarter. All annual fire safety equipment inspections are valid and up to date; Piper Fire Protection Company conducted the Fire Suppression System inspection on 1/7/25. Piper Fire Protection Company conducted the Sprinkler and Backflow Inspection on 12/5/24. Fire Master conducted the Fire Extinguisher inspection on 12/17/24.	For the Months of September and October of 2024 the second and third shifts were missing Fire Drill inspections.
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.	**Exception**	The agency's last combined Group Care and Food Inspection was conducted January 18th, 2024 with no corrections needed. The agency has four weeks of menus, which are posted in day room and dining room. Menus are signed by a registered dietician on September 12, 2024. All opened cold food is properly stored, marked and labeled. All operating Refrigerators and Freezers are clean an maintained with required temperatures. Freezers at 0 and -40 degrees and refrigerator at 40 degrees. One freezer is currently out of working order and not in service at this time.	The Satisfactory Residential Group Care Inspection report from the Department of Health was last completed on 1/18/24 (currently expired). There is email correspondence from the Agency's Program Director dated 1/10/25 to 1/21/25 with the DCF Representative for assistance in getting one current.
Additional Fire and Safety Health Hazards Narrative (if applicable)			

Youth Engagement			
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**Compliance**	The Agency provides a daily & weekend schedule depicting engaging, meaningful and structured activities, which included education, recreation, counseling services, life and social skill training during awake hours. Youth have access to physical activity daily, which exceeds the minimum of one hour. Faith-based activities are offered during the week for youth who want to partake. Those youth who do not want to attend spiritual services are offered non-punitive structured activities to attend instead. The Agency daily schedule includes opportunities for youth to complete homework, reading time and/or quiet time. The Agency has a programming schedule publicly posted in all common areas offering all youth access to educational, recreational, and counseling services daily.	
Additional Comments: **There are no additional comments for this indicator.**			
3.02 - Program Orientation			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES** If NO, explain here: The 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**	The Agency has a comprehensive orientation process and youth handbook that is provided to each youth during their intake process. Five of five records reviewed demonstrated orientation is completed 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**	The Agency has a comprehensive form that captures all contractual required information which is stored on an electronic platform. All five youth records reviewed had documentation to support the orientation addressed all required topics. Many of the topics were addressed in the youth handbook and the remaining topics were discussed verbally and documented on the admission documentation.	
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	**Compliance**	The Agency has aa completed orientation form that captures the signature of the youth and staff that is working with the youth at the time of intake.	
Additional Comments: **There are no additional comments for this indicator.**			
3.03 - Youth Room Assignment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.03		**YES** If NO, explain here: The 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**	All five reviewed youth records contained completed assessments addressing all required information needed to make an appropriate room assignment including: 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. Information found in the electronic system also supported information was obtained and considered when making the youth's room assignment.	

An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	**Compliance**	The Agency has a comprehensive Alert System that shows up when a youth present signs during their intake that requires an alert. All alerts are posted on an alert board in the nurse's office as well as on the census board in the hallway outside of the laundry room. The alerts are also on the agency's electronic tracking system. A comparison of the information within the record to the alert system confirmed the alerts were correct for all five youth.	
Additional Comments: **There are no additional comments for this indicator.**			
3.04 - Log Books			**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	**Compliance**	The Agency utilizes a hardcover logbook. The logbooks were reviewed for the past six months. Five random weeks of logbook entries were selected (August 17, 2024 to August 23, 2024 - September 28, 2024 to October 11, 2024 - November 2, 2024 to November 8, 2024 - December 7, 2024 to December 13, 2024). All entries that could affect the security and safety of the facility were highlighted to communicate with oncoming staff so they're informed.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	**Compliance**	All reviewed entries were legibly written and descriptive. Dates, times of incidents, events and/or activities and other pertinent information along with the name/signature of the staff and all others involved are evidenced in the logbook.	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**Compliance**	After review of the Agency's logbook for the five weeks selected, all staff recorded errors had the struck through method and contained staff initials as well as date. No use of white-out was used, all entries were made in ink (black, blue, purple and red) and no erasures or white out areas were found.	
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**	Over the past six months, evidence of weekly supervisory reviews of the logbook was observed. Entries are made in purple when the program director or designee reviews the log book.	

All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	**Exception**	A review of random weeks in the program's logbooks for the past six months show the program's practice is all direct care staff members document the start times of their shift, along with signature.	After reviewing a random sample of five weeks of logbook entries (August 17, 2024 to August 23, 2024; September 28, 2024 thru October 11, 2024; November 2, 2024 to November 8, 2024; and December 7, 2024 to December 13, 2024) this reviewer was unable to find where direct care staff upon starting their shift(s) reviewed the logbook for the previous two shifts with their signature at the time of entry.
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	**Compliance**	The Shift Supervisor makes the original entry in the log book to start the shift and then the other employees on shift take the log book and makes entries that they read missed shifts indicating the dates reviewed.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	Supervisions, resident counts, and home visit were well documented by staff throughout the logbook over the past six months.	
Additional Comments: **There are no additional comments for this indicator.**			
3.05 - Behavior Management Strategies			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.05		**YES** If NO, explain here: The 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**	Each youth is given a handbook at intake that clearly explains the behavior management system.	

Behavior Management Strategies must include:			
a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	**Compliance**	The Agency's BMS explains to the youth the consequences for any behavioral violations, such as level drops, earlier bed times, not able to attend outings, etc. Note: Room restriction is not used as part of the BMS and youth are never denied basic rights. Positive incentives, rewards and sanctions are explained within the Client Handbook and program documents. Steps for the Youth Development System (YDS) assist staff in their approach to utilize appropriate interventions to redirect youth and teach them new behaviors, as well as help them understand the consequences for their actions. Room restriction is not used in the use of the BMS. Youth are never denied their basic rights as a disciplinary measure. The Agency's BMS explains to the youth the consequences for any behavioral violations, such as level drops, earlier bed times, not able to attend outings, etc. Note: Room restriction is not used as part of the BMS and youth are never denied basic rights. The Agency uses a variety of perks, rewards and incentives to motivate and encourage youth to move their way up the four tier Level System (i.e. Rap House Store, outings, and a clock radio in youth bedrooms, just to name a few).	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	Per the Agency's P&P, and after speaking with the Program Director, all staff receive a bulk of their BMS training during their Managing Aggressive Behavior (MAB) training with a certified trainer.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	There's a P&P in place explaining protocol for feedback and evaluation of staff regarding their use of the BMS. The BMS is also discussed amongst the staff during the monthly team meetings and weekly treatment team meetings.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	Supervisors monitor the use of the BMS by staff to ensure that the level-based system is being practiced per policy. The Program Director / Supervisors discuss the BMS regularly during their Monthly Team Meetings, as well as Weekly Treatment Team Meetings. The client levels are consistently posted on a whiteboard in the Dayroom so that staff and youth are able to see each youth's status.	
Additional Comments: **There are no additional comments for this indicator.**			

3.06 - Staffing and Youth Supervision			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The 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 Agency maintains the required adequate staffing ratio, and maintains at a minimum two staff on 1st shift, three on 2nd shift and two on the 3rd shift. Evidence of staff-to-youth ratio was observed during the day at a 1:6 ratio and after review of the video surveillance staff-to youth ratio was at a 1:12 during the overnight.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	Staffing schedules reviewed show at least two staff are scheduled on each shift.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	**Compliance**	All employees must pass background screening and be properly trained prior to working on the floor with the youth. Shelter staff included in the staff-to-youth ratio were verified to be properly trained and background screened.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	A monthly staff schedule is posted in the copy room and sent out via email.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	The Agency keeps a list of all team members and if a staff happens to call out, the Lead/Manager/Director attempt to contact YDS staff until they're able to find 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	**Compliance**	Bed Check Dates/Times reviewed: January 11, 2025 - 2am-5am (All checks were completed in accordance to standard) • January 15, 2025 - 12:45am-4am (All checks were completed in accordance to standard) • January 21, 2025 - 1am-4am (All checks were completed in accordance to standard) • January 25, 2025 - 2am-5am (All checks were completed in accordance to standard) • January 29, 2025 - 1am-4am (All checks were completed in accordance to standard) - Dormitory consists of a Boys Wing & Girls Wing and divided by a large Control Room.	
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**	The agency has signs posted on the exterior of the building and in the main lobby stating cameras are in use. The agency recently upgraded to a more functional 360-degree angle video surveillance system, which provides a clear and concise picture quality. The system is capable of storing the video footage for a minimum of 30 days. The surveillance system records date, time and location. The facility is equipped with an emergency generator that keeps the camera system running if power goes out. Cameras are placed in all contractual areas. Cameras are placed in all contracted areas, as well as the exterior of the building. Cameras are excluded from youth sleeping areas and bathrooms.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	The video surveillance can be accessed off-site by the Program Director, Residential Supervisor, Team Leader, Senior Program Director of Residential and School Programs, and COO.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Exception**	The agency maintains a separate video surveillance log where reviews are to be documented in accordance to the standard. Supervisory review of video is noted in a Video Surveillance Log. Random and routine reasons for reviews are entered into the Video Surveillance Logs and consist of the Date Reviewed, Reason For Review, Date of Video that is being Reviewed, Specific Time Segment Reviewed, and Signature of Staff Reviewing Video. Weekly/bi-weekly reviews were conducted within the 14-day timeframe for the majority of the 6-month review span.	There is one missing review in the program's supervisory review log signified by a gap from 10/30/24 thru 12/16/24, however this reviewer did observe an entry in the program's logbook on 11/13/24 indicating a video surveillance review was completed. Observation of the agency's QI weekly report does note they're aware of this specific discrepancy and it was addressed with the supervisor.
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	Video Surveillance Reviews include the activities of the facility, as well as bed checks during the overnight shifts.	

Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	**Compliance**	The Agency has a P&P in place that grants the requesting party video recordings within 24 to 72 hours from the time of the request.	
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	**Compliance**	In the event that the video surveillance system is in need of service, the Program Director submits a work order to the facility manager / IT Technician to repair and/or refer to an outside company to obtain repairs.	
Additional Comments: **There are no additional comments for this indicator.**			
Standard Four – Mental Health/Health Services			
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**	A review of five youth mental health and medical records confirmed all youth had a healthcare screening completed upon admission. The screenings included: current medications, existing (acute and chronic medical) conditions, allergies, recent injuries or illnesses, presence of pain or other physical distress, observation for evidence of illness, injury, pain or physical distress, acute health symptoms requiring quarantine of isolation, observations of illness, injury, pain and tattoos, scars, or marking.	
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**	A review of five youth mental health and medical records indicate none of the youth admitted had chronic conditions.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**No eligible items for review**	An informal interview with the Program Director confirmed parental involvement is encouraged with all youth program needs.	

All medical referrals are documented on a daily log.	**No eligible items for review**	A review of five youth mental health and medical records reviewed indicated medical referrals were not applicable.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**No eligible items for review**	An informal interview with the Program Nurse indicated the program has a written policy and procedures which address a thorough referral process and follow-up medical care as required.	
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**	A review of six, three open and three closed mental health/medical records confirmed the suicide risk screenings occurred during the initial intake and the screening results were reviewed and signed by a supervisor	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	A review of documentation confirmed the program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	All four residential youth were placed on the appropriate level of supervision until assessed by a non-licensed professional working under the supervision of the licensed professional.	
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	**Compliance**	Four of the six residential youth files were observed for one-to-one supervision or constant supervision and was documented as required. The remaining two files were not applicable.	
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**	Four of the six residential youth files were observed to have documentation of time of day, behaviors, and initials in the observation log.	

Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	**Compliance**	Supervision level were not changed/reduced for any of the three youth until the non-licensed staff, under supervision of a licensed clinician, completed a further assessment.	
There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.	**Compliance**	Documentation of supervisory staff signature was observed on the observation logs, on each shift, for each youth of the three residential youth. The observation logs were kept in the youth's case file.	
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**No eligible items for review**	There were no youth (served in the community counseling program in the past six months) identified for suicide risk during intake.	
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**	There were no youth (served in the community counseling program in the past six months) identified for suicide risk during intake.	
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**	There were no youth (served in the community counseling program in the past six months) identified for suicide risk during intake.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	There were no youth (served in the community counseling program in the past six months) identified for suicide risk during intake.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	There were no youth (served in the community counseling program in the past six months) identified for suicide risk during intake.	
Additional Comments: **There are no additional comments for this indicator.**			

4.03 - Medications			Limited
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.	**Compliance**	The program's registered nurse (RN) holds an active and clear license valid through 4/30/26.	
The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication: a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse b. Evidence demonstrating their competency to assist with self-administration of medication distribution c. Maintenance of their annual medication training re-certification	**Compliance**	The program provided a list of trained staff who completed the in-person self-administration of medication by the RN, which included the staff competency to self-administer the medication.	
The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess: a. strategies implemented to reduce medication errors shelter wide b. analyze factors that contributed to medication errors c. allow staff the opportunity to practice and role-play solutions	**Compliance**	The program has documentation to support the RN provided a review of medication practices at the staff meeting held dated 12/30/2024 to reduce medication error and allow staff the opportunity to practice and role-play solutions.	
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	The agency has strategies implemented to ensure medications are provided within the two-hour time frame. The times of med pass are documented on the whiteboard in the medical room, staff alert board, and on the staff roster. There is an alarm in the medical room that is set to remind staff of med pass & has to be shut off manually.	
All non-licensed staff members are clearly identified and designated on the staff schedule and shift change report/shift responsibility form for assisting with the self-administration of medications on each shift	**Compliance**	The program lead carries a daily staff roster that identifies trained staff permitted to assist with medication distribution. In addition, the nurse maintains an updated list of the trained staff.	

The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.	**Compliance**	The agency has an alert board of each youth's medication, times, and dosages as well as a binder. If there are any medication updates each shift is notified by email at the beginning of the shift and it is noted in the staff logbook.	
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 delivery process of medications follows agency policy and procedures and Florida Network medication management and distribution policy. The program utilizes the Pyxis machine and physical binders to ensure appropriate medication management to promote a uniform policy and the safety in the medication process.	
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 an RN, there was a medication review conducted by an LPN or 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**	An informal interview with the Program Nurse indicated if on shift during an intake the nurse will meet with the youth and parent\guardian. When the RN is not duty the youth's medical records are reviewed by the RN within three business days. Two of two residential files reviewed confirm the supervisor reviewed all medication forms the day of intake.	
Medication Storage			

a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Pyxis ES Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL-LEFT TALL CABINET LOCK- LEFT, c BACK PANEL-RIGHT TALL CABINET LOCK- RIGHT	**Compliance**	All medications were stored in the Pyxis ES machine located in the locked medical room which is inaccessible to youth. There is a refrigerator in the medical room used to store medication that requires refrigeration. During the review period, there were no medications that needed to be refrigerated. Documentation supports that the refrigerator temperature is checked on a regular basis. There were no controlled substances stored in the Pyxis machine. The required Pyxis keys are located in a drawer in the medical room. All keys were accounted for and labeled as required.	
Medication Distribution			
a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual e. When nurse is on duty, medication processes are ALWAYS conducted by the nurse or when the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication. f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse	**Compliance**	The program has four site-specific system managers for the Pyxis ES Station. Only trained staff have access to the Pyxis machine and medical room. The medical distribution log is updated weekly. A monthly review of the Pyxis report is generated to monitor medication management practices. The program currently has one RN which distributes medication when on duty. The agency does not have or accept youth who are prescribed injectable medication except for epi-pens.	

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**	The program provided medication distribution logs from August 2024 through January 2025. Logs contain: the time of medication administration, youth's initials and dosage provided, staff initials and dosage provided.	
There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Exception**	Review of the program's medication distribution logs for the past six months showed time of administration for each youth receiving medication while in the residential program. It was observed that documentation was provided for each of the dates when medication was distributed outside of the required time frame and each occurrence was reported to the CCC as required.	Observation of incident reports and CCC reports confirm staff provided youth with medication outside the scheduled time of the ordered medication. The following dates were observed on: 08/06/2024, 08/27/2024, 09/22/2024, 09/29/2024, 10/14/2024, 10/29/2024, 11/02/2024, 11/02/2024, 11/25/2024, and 01/05/2025.
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	During the past six months there were no instances where youth missed their medication 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.	**Compliance**	RN on staff conducts retraining of five shelter staff for medication errors. The program provided verification of retraining for each occurrence prior to the staff members being assigned future medication administration responsibilities. There have been no occurrences of any staff making three errors within a one-year time frame.	

Medication Inventory			
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly and inventoried weekly c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Compliance**	During the time of review, there were no controlled substances, however; controlled substances and over the counter medication is stored in the Pyxis machine. All inventory counts are kept in the Pyxis and binder. Syringes are not used and are not kept on site. A "sharps" binder logs any sharp objects including scissors were locked in a lockbox in the medical room and were accounted for.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	Documentation confirms monthly Pyxis reports are reviewed to monitor medication management practices.	
Medication discrepancies are cleared after each shift.	**Compliance**	An informal interview with the RN indicated any medication discrepancies are cleared after each shift.	
Additional Comments: **There are no additional comments for this indicator.**			
4.04 - Medical/Mental Health Alert Process			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.04		**YES** If NO, explain here: The 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**	Youth with medical, mental health, or food allergy were appropriately placed on the programs alert system. The alert boards were located in the kitchen, the staff room.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The program's alert system includes medication and health conditions.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	The program provides a policy and procedure and training for staff to recognize medical/mental health problems.	

A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**Compliance**	Youth with medical, mental health, or food allergy were appropriately placed on the programs alert system. The alert boards were located in the kitchen and the staff room.	
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**	Four of the six records reviewed were not applicable, and the remaining records included documentation of an off-site incident report. One record confirmed verification of receipt of medical clearance, discharge instructions, parent/guardian notification and a daily log was observed for emergency care. Two occurrences of off-site emergency medical care were reported to the CCC. An emergency medical care episode took place on 12/17/2024 and no internal incident report was observed for this episodic event. The emergency care for the youth was logged in the program's logbook and the parents were notified. There is also documentation of receipt of treatment while at the hospital and follow-up treatment in the youth record.	
All staff are trained on emergency medical procedures	**Compliance**	All staff are appropriately trained in emergency medical procedures during on the job training and annual trainings.	
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 located in the staff room, living room, and laundry room/donation closet which are accessible to all staff.	
Additional Comments: **There are no additional comments for this indicator.**			