



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CDS-Interface Central

on 12/14/2016

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory:100.00%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

Standard 3: Shelter Care

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

Percent of indicators rated Satisfactory:100.00%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

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 and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory

Percent of indicators rated Satisfactory:100.00%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

Standard 4: Mental Health/Health Services

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

Percent of indicators rated Satisfactory:100.00%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

Percent of indicators rated Satisfactory:100.00%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

Rating Definitions

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

Satisfactory Compliance	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.

Review Team

Members

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Warren Garrison, Regional Monitor, Department of Juvenile Justice

Cayse Houston, Team Leader, Youth & Family Alternatives

Susan Spinella, VP Quality Assurance, Youth Crisis Center

Rodney Dailey, Supervisor, Orange County Youth & Family Services

Persons Interviewed

- | | | |
|---|--|---|
| <input checked="" type="checkbox"/> Chief Executive Officer | <input type="checkbox"/> Executive Director | <input type="checkbox"/> Chief Operating Officer |
| <input type="checkbox"/> Chief Financial Officer | <input checked="" type="checkbox"/> Program Director | <input checked="" type="checkbox"/> Program Manager |
| <input checked="" type="checkbox"/> Program Coordinator | <input checked="" type="checkbox"/> Direct- Care Full time | <input type="checkbox"/> Direct-Care Part Time |
| <input type="checkbox"/> Direct-Care On- Call | <input type="checkbox"/> Volunteer | <input type="checkbox"/> Intern |
| <input checked="" type="checkbox"/> Clinical Director | <input checked="" type="checkbox"/> Counselor Licensed | <input checked="" type="checkbox"/> Counselor Non- Licensed |
| <input checked="" type="checkbox"/> Case Manager | <input type="checkbox"/> Advocate | <input type="checkbox"/> Human Resources |
| <input checked="" type="checkbox"/> Nurse | | |
| 1 Case Managers | 0 Maintenance Personnel | 2 Clinical Staff |
| 1 Program Supervisors | 0 Food Service Personnel | 0 Other |
| 1 Health Care Staff | | |

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Fire Drill Log | 5 # Health Records |
| <input type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 # MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 5 # Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 10 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 5 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 5 # Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

6 Youth 6 Direct Care Staff

Observations During Review

- | | | |
|--|--|--|
| <input type="checkbox"/> Intake | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input checked="" type="checkbox"/> Program Activities | <input type="checkbox"/> Tool Inventory and Storage | <input checked="" type="checkbox"/> Facility and Grounds |
| <input type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage | <input checked="" type="checkbox"/> First Aid Kit(s) |
| <input type="checkbox"/> Searches | <input type="checkbox"/> Discharge | <input type="checkbox"/> Group |
| <input checked="" type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings | <input type="checkbox"/> Meals |
| <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input type="checkbox"/> Youth Movement and Counts | |
| <input checked="" type="checkbox"/> Medication Administration | <input checked="" type="checkbox"/> Staff Interactions with Youth | |

Comments

Items not marked were either not applicable or not available for review.
Rating Narrative

Strengths and Innovative Approaches

Rating Narrative

In the past six months since the last on-site review the agency has named a new C.O.O. The previous C.O.O. retired and Tracy Ousley was recently promoted to the position.

The agency has plans in place to begin work on the shelter and hopefully secure a new site in the next year or so.

The agency continues to maintain longevity of their staff.

The agency has created a comfort room within the shelter to deal with trauma sensitive care.

Case Managers and Counselors have been working with parents on implementing the Behavior Management System in the home. They are teaching the parents the system to use during home visits and after release from the shelter.

A new Non-Residential Regional Coordinator has been hired since the last on-site review.

Three new Non-Residential Counselors have been hired.

Standard 1: Management Accountability

Overview

Narrative

CDS Family and Behavioral Health Services, Inc. – Interface Youth Program Central provides both residential and non-residential programs. This program site is located in Gainesville, Florida. The CDS-Central program provides services through a direct local service provider contract with the Florida Network of Youth and Family Services (FNYFS). The CDS-Central agency primarily provides CINS/FINS services in Alachua, Gilchrist and Levy Counties. CDS-Central also operates sister Residential and Non-Residential programs in Lake City and Palatka, Florida respectively. All three CINS/FINS program locations report to the agency’s Chief Executive Officer and Chief Operations Officer that are located in the headquarters office in Gainesville, Florida.

The daily operations of CDS-Central residential and non-residential programs are overseen by a Regional Coordinator. The Regional Coordinator position is the highest ranking position for the agency at this location. The agency also has Residential and Non-Residential counselors, Residential Direct Care and Non-Residential staff members. The agency has a Centralized Human Resources and fiscal departments that are responsible for all personnel and financial matters respectively. All CDS Residential Shelters and Non-Residential Programs have implemented uniform operating protocols for all three service locations in their respective service areas. Other uniform program and operations protocol for all three locations include training and professional development exercises.

The agency conducts background screenings prior to the hiring of all staff members. All staff members receive on the job training at their respective service locations. In addition, many agency training's are consolidated to reduce costs and ensure that all staff members receive standardized training. The agency conducts outreach throughout their designated service regions to local youth, parents/guardians, local community organizations, partners, and stakeholders.

The agency utilizes various data collection methods. Designated agency leadership teams develop monthly and quarterly reports that focus on accountability, risk management, contract deliverables, programming and operations. Reports are analyzed by specific staff and specific strategies are developed to address identified issues and goals accordingly.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedure to ensure the safety of the persons served by CDS and to comply with the regulations and protocols as defined by the Florida’s Department of Juvenile Justice (DJJ) and The Department of Children and Families (DCF). According to the policy, when a supervisor/coordinator identifies a person not currently employed by CDS as a potential hire or volunteer, he/she must facilitate the completion of a Background Screening packet to determine the applicant’s eligibility for hire. The background screening procedures clearly delineates each step to be followed.

The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Department on January 8, 2016.

There have been five staff and fifteen volunteers hired since the last review. Background screening documentation showed each staff and volunteer obtained eligibility prior to working with youth. No staff was eligible for a five year re-screening.

There were no exceptions to this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program policy promotes an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. The policy addresses the employee/volunteer responsibilities to ensure the program is providing an abuse free environment.

There were five staff and fifteen volunteers hired since the last review. Each staff/volunteer record reviewed contained signed documentation of being trained on child abuse reporting. Staff/volunteer records also contained signed acknowledgement of the standards of conduct. Upon conducting facility tour, the program had ten postings of the child abuse hotline number in various locations. The facility had two grievance boxes-- one for the male and female living areas. All instances of physical and/or psychological, verbal intimidation, use of profanity is addressed in the policy and requires management to take action immediately. Interviews with staff indicate a strong commitment to provide the youth served at the program an abuse-free environment.

There were no exceptions to this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place to ensure reporting of all incidents are consistent with the requirements of appropriate state agencies and all incidents are properly documented within the required time-frame. The policy clearly delineates each procedure and process to ensure the reporting and documentation of all incidents are accurate and appropriate.

A review of six Central Communication Center (CCC) reports for the last six months found each report was completed within the allowed two hour frame. Each report was documented in the programs log and on the incident reporting forms. Each report was successfully closed out with all supporting documentation.

There were no exceptions to this indicator.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

Agency policy at CDS Interface is reflected in a comprehensive training plan outlining which staff positions are to receive each specific training, and when (such as at hire, within 120 days, or annually). The plan also explains where training material may be found, or in the case of off-site training, where it may be obtained. This plan was created in 2009, and reviewed and updated at least annually since that time.

Staff are made aware upon hire of the training requirements for their position, and are given assignment on which classes to attend online or in classroom settings. Outside trainers are often utilized for group training at CDS Interface.

In order to ascertain whether training goals were being met, ten staff training files were reviewed for compliance (five were long-term employees who had been with the agency anywhere from 2 years to 22 years). The other five were newer employees who were within their first year of hire. Two of those five were fairly recent hires, who had not yet completed the 120 period. Those two staff had already substantially met their initial requirements with minimal exception, and the long-term employees had met their annual training goals. The training files reviewed listed cumulative training totals as well as topics and certificates.

There were no exceptions to this indicator.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The agency does have a policy that coincides with this indicator.

The agency does have procedures that coincides with this indicator.

The agency compiles monthly outcome data reports that cover all of their programs by funding source and personnel. They produce monthly and annual outcome reports and Corrective Action Plans (CAP) are generated to address any deficiencies that were identified from these reports. The reports address information from NetMIS and other data sources within CDS that included the following: monthly staff and unit performance and projections, missing youth documents, the number of 30 and 60-day follow-ups: late, early, and current, current number of monthly youth screenings, number of drills conducted each month, number of youth admitted and discharged from their programs, the number of youth served requiring emergency shelter placement, the number of youth active longer than 12 weeks, medical emergencies, internal personnel and DJJ (CCC) incident summaries, and current staff caseloads. The report is also broken down to address individual staff performance in monthly and YTD increments. The report identified program performance projections needed to meet contractual requirements. Staff meeting minutes for the last six months were reviewed and showed that this information is addressed and discussed during those meetings.

Case records are reviewed quarterly. Documentation was provided to show a review of the case records for the last quarter. Checklist were provided for each case record reviewed that documented the problem identified, the counselor response, and the outcome. Employee satisfaction surveys are completed every two years. The last round of surveys, which covered the time frame of 8/18/2015 to 9/30/2015, were provided and reviewed. The next round of surveys will start in the summer of 2017. The agency also completes client satisfaction surveys. The surveys are completed with the youth and their parent/guardian on the second to last family session prior to going home.

There were no exceptions to this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

Agency has a clear and comprehensive policy on handling client transportation. The policy follows FL

Network and DJJ policies on preventing impropriety by having a third party present in vehicles during client transportation. The CDS policy outlines which staff may transport and under what circumstances. There is a procedure in place for any staff who incur traffic violations while employed at CDS Interface. A policy outlines the documentation of travel, to include the name of driver, purpose of trip, date and time, location of travel, number of passengers and their identities. The majority of trips documented were to and from schools or for outings.

There is a log of vehicle maintenance, registration, and procedures. In addition, there are logs of actual vehicle usage which do include parties transported, driver, and all information outlined in the policy. One log is specifically for trips to schools. The other log is to document use of vehicles for outings. Both are set up in similar manner. A unique process that CDS uses is that once a client is on site as a resident they are 'cleared' and added to list of names of youth that may be transported. This takes place only if no situation precludes them from riding with others. In the rare instances where a client is not cleared, or loses clearance, a supervisor must give permission for any transport of that client. That supervision is documented in Professional Logs. Both clients and staff who are cleared to transport clients are listed in Transportation Logs. These logs were reviewed and appear to be comprehensive and up-to-date. It is noted in these same logs who the second staff person is for each trip.

There are no exceptions to this indicator.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The program has cooperative agreements with fifty-nine stake holders and partners. Fifty-six of the cooperative agreements expires in June of 2017 and three agreements are ongoing. A list of the cooperative agreements are maintained in a binder along with sign-in sheets and minutes for each meeting attended by the program. The program maintains a written agreement with each partner, to include services which are being provided and a referral form.

Included in the binder is an Outreach Plan for targeting youth for services and roles of responsibility for the Outreach program. The intent of the Outreach Plan is to ensure youth (mostly to become adjudicated delinquent who reside in high crime zip codes with the highest number of delinquency referrals and who have identified risk factors as identified by the Department of Juvenile Justice) are prioritized for Outreach Services.

Since the last review conducted in May 2016, the program has attended two Circuit 8 Board meeting according to sign-in sheets provided.

There are no exceptions to this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The Non-Residential Counseling Program provides services for youth and their families primarily in Alachua, Gilchrest, and Levy Counties. The program receives calls for services from parents, guardians, system partners, and the general community. The non-residential component for CDS Central consists of five Non-Residential Counselors; three of which are Master's level Counselors, one holds a Ph.D., and one is a Bachelor's level counselor. All Family Action Staff members and residential counseling staff members have access to the agency's Non-Residential Regional Coordinator, who is a Licensed Mental Health Counselor (LMHC). The agency also contracts with the former C.O.O. who is also a LMHC, for supervision services for the non-licensed counselors.

The screening determines eligible youth and family whom are referred to the respective residential or non-residential program to start the intake process. If the program is full at the time of referral the agency will make a referral for the family to another appropriate community agency, according to the youth's zip code.

The program has the capability to offer both case management and substance abuse prevention education on an as needed basis. The agency conducts Case Staffing's, which are statutorily-mandated committees that develop formalized treatment plans for status offenders when all other services have been exhausted. If needed, the Case Staffing Committee can also recommend the filing of a CINS Petition with the court.

Both the Residential Supervisor and residential and non-residential CDS-Central counseling staff are engaged in partnerships with local school systems regarding the options available for status offenders and the overall petitions process and displayed a high level of knowledge and insight regarding their involvement in the community in this area.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy in place which was last updated/reviewed in March 2011. The policy in place meets all the standards outlined in the CQI Indicator. The agency also has a written policy for their intake process which was last updated/reviewed in November 2014. The policy meets all the standards outlined in the CQI Indicator.

The provider's procedure requires trained staff to complete the intake screening process upon receipt of the referral within 24 hours, but no later than 7 calendar days. The provider's procedures also state that upon completion of the intake screening, the intake/assessment process needs to be initiated within 7 days along with necessary assessments.

A total of five residential files (three open and two closed) and five non-residential files (three open and two closed) were reviewed. All files reviewed had completed an intake screening, and then initiated the intake process in a timely manner. Staff initiated contact with families to complete non-residential screenings within a day of receiving the referral for the five files reviewed. There is an 'Action Taken' box where staff can make notations as to whether or not the youth is accepted and a place for notes about the intake set-up.

There is evidence of the provider meeting the standards by giving the youth and their parents/guardians necessary paperwork during the intake process. The provider gives each youth and parent/guardian an Orientation Packet which they sign stating they received the following, but not limited to: the orientation packet, that they are aware of the services available to them, they were explained of their family's rights and responsibilities, and they understand the grievance process.

There were no exceptions to this indicator.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy in place which was last updated/reviewed in November 2014. The policy in place meets all the standards outlined in the CQI Indicator.

The provider's procedure requires a Bachelor's or Master's level staff member to initiate or attempt the Needs Assessment within 72 hours of admission, and completed within two to three face-to-face contacts following the initial intake. The provider requires the counselor/case manager to sign and date the Needs Assessment form corresponding to the date of completion. The supervisor is then required to review and sign the completed document.

A total of five residential files (three open and two closed) and five non-residential files (three open and two closed) were reviewed. Of those files, the Needs Assessment was initiated by a Bachelor's or Master's level staff within 72 hours of admission and completed within two face-to-face contacts in all cases reviewed. They are all signed by the counselor who completed the Needs Assessment and their supervisor. Of those files reviewed, three youth identified with an elevated risk of suicide as a result from the Needs Assessment and were further assessed for suicide risk under the direct supervision of a licensed mental health professional.

There were no exceptions to this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy in place which was last updated/reviewed in November 2014. The policy in place meets all the standards outlined in the CQI Indicator.

The provider's procedure requires an Individual Plan to be developed with the youth and family within seven working days, following completion of the assessment. They outline all the requirements for each Individual Plan that needs to be included, which corresponds to the requirements outlined in the CQI Indicator.

A total of five residential files (three open and two closed) and five non-residential files (three open and two closed) were reviewed. Of those files, all ten had completed the youth's Individual plan within seven days following completion of the assessment. If the youth was still at the shelter after 30 days from the initial implementation of their Individual Plan, then the Individual Plan was reviewed with all the necessary parties involved well before the due date. Each Individual Plan was neatly typed up and organized with all the necessary components. They were easy for youth and families to understand and were reachable goals.

There were no exceptions to this indicator.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy in place which was last updated/reviewed in July 2014. The policy in place meets all the standards outlined in the CQI Indicator.

The provider's procedure requires the assigned counselor/case manager/residential counselor to be responsible for providing the individual and family counseling based on the Individual Plan. They are responsible to follow the youth's case and ensure delivery of services through direct provision of services or referrals. This process includes the following:

- Establish referral needs and coordinate referrals based on the ongoing assessment of the youth/family problems and needs identified in the Individual Plan
- Coordinate Individual Plan implementations
- Monitoring youth's/family's progress in services and providing support for the families
- Monitoring out-of-home placement, if necessary
- Making referrals to the case staffing committee, as needed to address the problems and needs of the youth/family
- Recommending and pursuing judicial intervention in cases as appropriate
- Accompanying youth and parent/guardian to court hearings and related appointments, if applicable
- Making referrals to additional services, if needed
- Continued case monitoring and review of court orders
- Case termination with follow-up.

A total of five residential files (three open and two closed) and five non-residential files (three open and two closed) were reviewed. The youth's Individual Plan was implemented in a counseling session which was notated in many places in the counselor's notes. The notes also documented the progress the youth and family were making with their goals and plans. In the counselor notes, it was stated that resources were discussed with the youth and family for them to utilize. Also documented were parent phone calls that the counselors held. The thirty and sixty day follow-ups are assigned at discharge and completed by the assigned person. Each youth that was discharged, in the files reviewed, was discharged with referrals for the youth and family.

There were no exceptions to this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy in place which was last updated/reviewed in July 2014. The policy in place meets all the standards. Although it does not state in this particular policy that the counselors must adhere to all laws regarding confidentiality, it is stated in the policy for Youth Case Records that all CDS staff will adhere to all confidentiality laws.

The provider's procedure requires the counselor/case manager/residential counselor to be responsible for documenting all contacts in progress notes and maintaining them in the participant's file, including regular contact with the youth and family and any outside service providers applicable to the Individual Plan to ensure continuity of care and to monitor delivery of services.

Residential counselors are required to provide:

- individual counseling based on the Individual Plan
- group counseling sessions based on established group process procedures; which are to be conducted a minimum of 5 days per week focusing on issues facing adolescents.

Non-residential counselors provide services by the Family Action Program, a therapeutic community-based service designed to provide the intervention necessary to:

- stabilize the family in the event of a crisis
- keep families intact
- minimize out-of-home placement
- provide aftercare services for youth returning home from shelter services
- prevent the involvement of families in the delinquency and dependency systems.

A total of five residential files (three open and two closed) and five non-residential files (three open and two closed) were reviewed. Of those files, all had documented counseling sessions that the counselor had conducted both individual sessions and family sessions. The majority of counselor/case manager/residential counselor notes were neatly typed up and signed by necessary persons involved. Groups were documented for each individual youth in their files for at least five groups a week, if not more.

There were no exceptions to this indicator.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy in place which was last updated/reviewed in February 2008. The policy in place meets all the standards outlined in the CQI Indicator.

The provider's procedure states that a Case Staffing Committee meeting is to be convened to review cases determined in need of services or treatment if:

- the family or youth is not in agreement with the services or treatment offered
- the family or youth will not participate in the services or treatment selected
- the counselor/case manager needs assistance in developing an appropriate Individual Plan
- the parent, guardian, or custodian or any member of the committee requests that a Case Staffing Committee meeting be convened. (If requested by a parent, a Case Staffing Committee meeting must be held within 7 days, excluding weekends and holidays, of written request.)

The counselor/case manager is responsible for implementing and monitoring the Plan of Services. A copy

is required to be sent to the parent/guardian within 7 days of the meeting to provide a written report outlining reasons for or against a petition being filed and the recommendations. The Case Staffing Committee must include, but not limited to, the following:

- a representative from the Department of Juvenile Justice or designee in accordance with the CINS/FINS Operations Manual
- a representative of the CINS/FINS provider
- a representative of the youth's school district.

Provider did not have any cases that went to case staffing/petition within the past six months.

There were no exceptions to this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy in place which was last updated/reviewed in September 2015. The policy in place meets all the standards outlined in the CQI Indicator.

The provider's procedure requires that an official record shall be maintained for each youth receiving services upon admission. Staff shall establish a case record for each youth in a consistent and orderly manner. Youth records should include all pertinent information about the youth's case and the case records are required to be marked "confidential" while being maintained in a locked cabinet or a locked room with controlled access, which is centrally located and available to program staff. All records that are transported are locked in an opaque container that is marked confidential.

A total of five residential files (three open and two closed) and five non-residential files (three open and two closed) were reviewed. Of those files, all were marked "confidential". The provider has a hard-cased box that locks and is marked "confidential" to transport necessary files and paperwork. The provider has locked cabinets that house their files which are also in a locked controlled room. All files reviewed were neat and orderly, and very easy to guide through.

There were no exceptions to this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The CDS-Central youth shelter is located in Gainesville, Florida in Alachua County. The CDS-Central facility operates twenty-four hours per day, seven days per week and is licensed by the Department of Children and families for twenty beds. The agency serves both CINS/FINS and DCF program participants.

The shelter is comprised of a detached building that is a one level landscape or ranch style design. The shelter has both a front and side entrance. The building is designed with equally sized dorms and day rooms for female and male residential clients. Each residential section of the shelter can accommodate up to ten to twelve residents. The female and male sides of the facility are equipped with a large dorm, bathrooms, and a dayroom. The facility includes a kitchen and dining area, Youth Care Work station, staff offices, a smaller meeting room, multipurpose recreation, and an instruction/class room. Youth that are not in school spend a majority of their free time in the dayroom either engaged in planned life skills activities, playing video games, watching television, or completing homework assignments on the computers. Youth attend local area schools if they are not on suspension, expulsion, or suffering from an illness.

The exterior of the facility is well-maintained and the grounds are landscaped. The facility site has limited green space, but does have an open court in the rear of the facility. The rear area of the facility is enclosed by private wood fencing.

The program staff for the Residential staff includes a Regional Coordinator; a Residential Supervisor; one Senior Youth Care Worker; twenty-one full-time, part-time and PRN Youth Care Workers; one administrative staff person; and one Registered Nurse. Two Residential Counselors are assigned to provide counseling and case management services to the residential program. The Youth Care Workers are primarily responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision, and general assistance.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The Program has a policy and procedure in place which the program provides a safe, clean, neat, and well maintained wholesome living environment for the youth they serve. In addition the program provides structured daily programming to engage youth in activities that foster health, social, emotional, intellectual, and physical development.

Upon completing the entrance interview with the QI Review Team and Program Leadership, a tour of the facility was provided by a designated program staff member. The tour, as well as, the CEO of the Agency revealed that the facility is old and dated. However, the CEO revealed that the agency is in the process securing funding for a new facility but a definitive date has not been established.

During the initial tour of the facility a strong smell of urine permeated the air in the male dorm. However, a later observation of the bathroom revealed that this issue had been addressed. Client rooms appeared to be clean and well kept with no visible graffiti on the walls or furniture. Each youth was assigned to his or her individual bed with appropriate linens and blankets. In addition there was appropriate lighting in both the male and female dorms. The facility was well maintained and the grounds were free of trash and debris.

A review of facility binders reveal that the program had monthly and quarterly inspections for insects and fire respectively. The program also provided a posted daily schedule for the youth to engage in meaningful, structured activities (education, recreation, counseling, life skills and leisure activities etc... with limited idle time).

In addition, a review of three open and two closed youth files revealed that the youth routinely participated in the aforementioned daily activities.

There were no exceptions to this indicator.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure in place detailing the Program Orientation in which each youth is provided within twenty-four hours of entering the facility.

Upon entering the facility and completing the intake process each youth is provided a detailed orientation by program staff informing the youth (but not limited) to the following:

- . Program dress code
- . List of prohibited contraband
- . The Grievance procedure
- . Physical layout of the facility
- . Visitation, mail & telephone procedure
- . Access to medical & mental health procedure
- . Room Assignments
- . Disciplinary actions.

There were five youth files reviewed, three open and two closed. The program provides a detailed orientation to each youth entering the facility upon the youth completing the intake process. There was documentation within each youth file indicating that program orientation was completed by program staff with each youth. Each youth and staff member signed off on the program orientation and parents are also made aware of the orientation during the intake process.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure in place regarding Room Assignment and sleeping arrangements. According to the program, this policy was established with the intent to ensure that each youth is protected from harm and that safety and order is maintained.

Upon the program staff completing the Intake Assessment, each is assigned a room or bed based on the information provided by the youth, parent or guardian, and outside related sources that may have knowledge of the youths history. Several factor's are taken into consideration when assigning a youth to a room and are not limited to the following:

- . Gang affiliation
- . Suicide Risk
- . Prior delinquent history
- . Current alleged offenses
- . Physical characteristics
- . Age
- . Attitude
- . Past aggressive behavior.

A review of the program's policy, five youth files, staff interviews, and observations revealed that all of the aforementioned factors are considered when youth are assigned to a room. In the facility, there is only one large room for males and one for females. However, program staff were able to identify how the youth are assigned to specific beds based on the factors listed above.

There were no exceptions to this indicator.

3.04 Log Books

Satisfactory Limited Failed

Rating Narrative

The program has a policy and procedure in place regarding the program Log Book. This policy was established with the intent to ensure that daily program occurrences are captured in a permanent, bound book.

According to the program's policy it is the responsibility of the shift leader to ensure that appropriate documentation occurs on each shift. The program Log Book shall document, but is not limited to, the following:

- . All incident when physical intervention used
- . Intakes and Dispositions of youth
- . The staff on duty
- . That the security of the building has been checked
- . All incidents including when youth leave and return to the general population
- . Any current deficiencies in the program
- . A review of the program log by the incoming shift leader and staff of the previous three shifts in order to be familiar with activity on prior shifts, unusual occurrences or problems. A signature title and date shall be documented accordingly.
- . Weekly review by the Program Manager, Supervisor or designee with corrections, recommendations, directives or followup.
- . Any other pertinent information (i.e. schedule contacts, visits, meetings).

A review of Program Log Books for the past (4) months revealed that the program is doing an overall satisfactory job with its Log book documentation. However, the observation of the Log Books also revealed that line staff are not consistent with signing in the log and reviewing its content from previous shifts.

It should be noted that there is routine documentation, review and direction by the program Supervisors to their staff within the Logbooks. A review of the Logbooks did not reveal any whiteout and all corrections were struck through with one line and initialed by the staff member.

There were no exceptions to this indicator.

3.05 Behavior Management Strategies

Satisfactory
 Limited
 Failed

Rating Narrative

The program has a policy in place governing its client Behavior Management System. The intent of the following policy is to ensure that a consistent and fair system of privileges and consequences exist within the program.

Upon completing the Intake process each youth is apprised of the program's Client Behavior Management System during the orientation. It's an intensive teaching system used to teach the participant who has engaged in serious, inappropriate behaviors the alternatives to appropriate behaviors.

A review of five youth files, interview with the Program Manager, policy, and Behavior Management System handbook revealed that the program has a thorough system in place to:

- . Maintain order & security
- . Promote safety, respect and fairness and protection of rights
- . Promote opportunities for positive reinforcement and recognition
- . Minimize the separation of youth from general population
- . Behavioral intervention strategies that utilize the least amount of force necessary to address the situation and ensure basic rights are not violated.

There are no exceptions to this indicator.

3.06 Staffing and Youth Supervision

Satisfactory
 Limited
 Failed

Rating Narrative

It is the policy of CDS Interface that the residential programs maintain the minimum staffing ratio of 1 staff to 6 youth during awake hours, and 1 staff member to 12 youth during sleeping hours for the youth - with at least one staff on duty of same gender as youth within ratio. According to written policies, the Regional Coordinator or designee are responsible for scheduling and ensuring coverage. If a staff member is on

duty and his/her replacement does not arrive for unforeseen circumstances, that staff member is required to stay until an appropriate replacement is in place.

The policy includes clear instructions on bedtime supervision and bed checks. Female staff check on female clients and male staff check on male clients every 15 minutes. Provisions are made for constant sight/sound supervision when necessary so that ratios are maintained at all times.

Ratios are maintained by management team scheduling staff in a manner that is flexible to the needs of the client demographic at any given time. The bed checks are completed electronically with a wand and a printable report by each shift. The reports are kept in a binder (males have one binder, females another) both which were reviewed by this writer to ensure accuracy of reporting process. This process leaves very little room for human error. Machines do break down on occasion, but the integrity of the reporting process appears sound.

There were no exceptions to this indicator.

3.07 Special Populations

Satisfactory
 Limited
 Failed

Rating Narrative

The CDS policy is that they shall participate as members of Florida Network of Youth and Family Services' continuum of care shelters which are designed to serve court-ordered youth including special populations such as staff secure, probation respite, and domestic violence respite. There are policies in place for enhanced supervision, in-depth orientations, assessments and service planning, as well as enhanced parental involvement and collaborative aftercare.

Procedures are in place for all special population categories including contacting Florida Network as appropriate. Length of stay is noted for each population in procedure as well as policy statements. Procedures denote required time frames to include NETMIS entries and other documentation. Procedures include enhanced ratio of staff to client when required for special populations.

In practice, CDS has only served a few clients from special populations since their last review. All were Domestic Violence cases. This writer was able to review three DV client files in which the following was noted:

- . Comprehensive progress notes were maintained.
- . Program eligibility was documented.
- . Dates of program participation were noted to be within appropriate limits.
- . Aftercare plans were documented, to include a client transferring to CINS/FINS when appropriate.
- . Parental involvement in counseling and other activities were well documented. When parents or guardians were less than compliant, that fact and attempts to reach them were documented.

There were no exceptions to this indicator.

3.08 Video Surveillance System

Satisfactory
 Limited
 Failed

Rating Narrative

The policy at CDS is that residential shelter maintains a video surveillance system that operates 24 hours per day, 7 days per week. The cameras are placed strategically, so that they may capture outside activity, entry ways, other hallways, and staff stations. The system is accessible to designated staff, to include off-site capability. Supervisory review of the weekly activities on video is conducted bi-weekly and noted in logbook. Cameras are able to record date, time, and location, and maintain resolution that enables facial recognition of person on film.

No cameras are to be placed in sleeping or bathroom areas. Cameras are to be visible to persons in area. Cameras will have capability of recording and saving portions that may be needed for incident/CCC purposes.

The procedure at CDS is the placement of cameras in strategic locations such as outside areas, entry points and hallways and staff stations to record and observe that activities occurring are appropriate and also for the safety of clients as well as staff. Cameras are visible to persons in area, and clients and staff are made aware of their location. Requests for video clips are made available to appropriate parties when requested between 24 and 72 hours from time of request. Efforts are made to expedite such requests. Video images are stored for a minimum of 30 days, but usually for 90 days. If a video is required for documentation of an incident or alleged incident, it can be stored indefinitely. This occurs as needed at CDS.

This writer was able to view video surveillance footage from as recently as this week, and as long as 90 days ago. I was able to observe the video footage and identify staff members I had met, as the clarity was excellent. The type of system was called True Vision and it had been purchased within the past year. I observed video of clients coming into residential shelter from school or other outing and being checked for contraband with wand. A second staff member was present for risk prevention. The zone where clients are checked with wand is near front door, and is clearly marked with yellow tape. Appropriate notices are posted regarding the fact that video surveillance is utilized. Cameras were easy to see, and were not placed in any inappropriate locations. When necessary, video footage can be saved indefinitely. I was able to observe past video clips that had been saved in a file. Two key staff have access to the stored video surveillance. They are the Regional Coordinator and the Residential Supervisor. The Regional Coordinator also had access to the system via her mobile phone. Other residential staff had access to the viewing of current video during their shift.

There is a backup system in place so that even if there is a power outage, the video system can be retroactively viewed. Log books were noted to reflect supervisory review of video footage.

There were no exceptions to this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The CDS-Central program has specific policies and procedures related to the admission, screening, interviewing, client inventory, and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. Upon admission, program staff will conduct a full intake interview with the youth and parent/guardian. An initial assessment occurs to determine the most appropriate room assignment given the youth's needs and issues, the current population at the facility, physical space available, and staff's assessment of the youth's ability to function effectively within program rules and expectations. CDS Central staff members conducting the initial interview and assessment considers the residents' health and mental health status, physical characteristics, maturity level, history including gang or criminal involvement, school performance, and family dynamics. Staff members on duty at the time of admission immediately identify youth who are admitted with special needs and risks; such as risk of suicide, mental health, substance abuse, physical health, or security risk factors. The agency's Non-Residential Regional Coordinator is a Licensed Mental Health Counselor (LMHC). The agency also contracts with the former C.O.O., who is also a LMHC, to provide supervision services for the non-licensed counselors.

When a youth indicates positive for suicide risk they are placed on Constant Supervision or One-to-One Supervision. The agency utilizes a daily logbook documentation system and an alert board as part of its internal medical/mental health alert system. The agency operates a detailed medication distribution system using the Pyxis Med-Station 4000 Medication Cabinet.

The program has a Registered Nurse (RN) on-site at least five days a week. The shelter has a list of staff members that are authorized to distribute medication. The facility is equipped with multiple first aid kits, knife for life and wire cutters. The staff are trained to provide CPR and First Aid services in case of an emergency. Staff members are also trained on fire safety techniques and various emergencies. As of the date of this onsite review, all fire safety equipment is up-to-date and functioning as required.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Preliminary Physical Health Screening. This policy was last and updated in November 2016.

Upon admission to the shelter each youth is screened in order to obtain information related to the youth's physical status. This information is recorded on the Intake/Assessment Form. The staff person completing the form should note on page 6 of the Intake/Assessment Form any areas of concern and/or need to follow up and initiate the Medical/Mental Health Alert system if applicable.

Upon admission to shelter services, the youth and parent or guardian shall be interviewed about the youth's current medications. This shall be part of the Medical and Mental Health Assessment screening process. This process will be conducted by on-duty staff and reviewed by the Registered Nurse within five business days.

A total of five files were reviewed to assess requirements of this indicator. Of the five files reviewed, all contained the Intake/Assessment form with all health screening sections completed. The agency also captured additional health screening information on a "Screening Health Addendum". This form captures whether the youth is eligible to receive services and screens for any "yes" response to six health related questions. These questions ask the youth "In the last 48 hours have you experienced any Fever; Diarrhea; Vomiting; Sore Throat; Continuous coughing and/or sneezing; and cold like symptoms". All five files

reviewed also contained this form completed. None of the youth required any follow-up medical care; however, there are procedures in place if it is needed.

Once the intake process is complete, the intake staff person and a supervisor or shift leader reviews the packet including the Intake/Assessment Form. Any health concerns that require a follow-up are addressed at that time through consultation with the parent/guardian. If the parent/guardian is unavailable, attempts are made to contact the youth's physician. Of the five files reviewed, three youth were on medication and the medications, as well as, the reasons for the medication were documented. There was one youth with allergies and the file documented it was an allergy to cats.

There were no exceptions to this indicator.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency has policy on Suicide Assessment addressing the requirements of this indicator. The policy was last reviewed in August 2011.

The initial suicide risk screening consists of the six questions on the Intake/Assessment form. If a youth answers "yes" to any of the six questions the youth will be placed on constant sight and sound supervision until a full suicide assessment is conducted. If the youth is an immediate danger to themselves or others, the youth will be placed on one-to-one supervision and staff will immediately call 911 and request assistance for law enforcement for a baker act. If at any time during the youth's stay in the shelter, the youth expresses any suicidal thoughts or ideations the youth is placed on constant sight and sound supervision until a full risk assessment is completed by a qualified staff.

The agency has two levels of supervision. One-to-one supervision is the most intense level and is used for youth waiting to be removed from the program by law enforcement for a baker act. One staff member, who must be the same gender as the youth, will remain within arm's length of the youth at all times. The second level of supervision, Constant Sight and Sound Supervision, is for youth who are identified as being high risk of suicide but are not expressing current suicidal thoughts or threats. A staff member must have continuous, unobstructed, and uninterrupted sight of the youth and be able to hear the youth. Staff assigned to monitor the youth must document his/her observations of the youth's behavior at intervals of thirty minutes or less for both one-to-one supervision and constant sight and sound supervision.

The agency's Non-Residential Regional Coordinator is a Licensed Mental Health Counselor (LMHC). The agency also contracts with an additional LMHC, who was the former COO, to provide oversight and conduct supervisions of the non-licensed counselors.

There were four youth files reviewed for youth who had been placed on suicide precautions. All four youth were placed on suicide precautions at intake due to issues identified during the screening process. All youth remained on sight and sound supervision until assessed by a qualified professional. All youth were seen and assessed by a counselor using a suicide risk assessment within twenty-four hours. All suicide risk assessments contained documentation of consultation with an LMHC. All risk assessments were faxed to the LMHC for review and signature. All youth were placed on normal supervision levels upon completion of the assessment. All four youth had observations documented at least every thirty minutes the entire time they were on suicide precautions. Two of the four suicide precaution events were documented in the logbook and two were not.

Exception:

There were two suicide precaution incidents that were not documented in the program logbook.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a very detailed policy on Medication Provision, Storage, Access, Inventory, and Disposal. The policy was last reviewed in September 2016.

The policy has detailed procedures for Prescription Medication, Verification of Medication, First Aid and Over-the-Counter Medication, Utilization of the Pyxis Med-Station 4000, Medication Provision, Supervision, and Monitoring, Medication Errors and Refusals, Medication Storage, Access to Medication, Inventory Procedures, Medication Counting Procedures, Discharge of Youth with Medication, and Disposal.

The shelter provided a list of staff who are trained to supervise the self-administration of medications. There were two staff on that list who were listed as “Super Users” for the Pyxis Med-Station, with one of those staff being the Registered Nurse (RN).

The shelter has a RN who has been employed at the shelter since February 2016. The RN is on-site seven days a week, totaling approximately twenty hours a week. The RN is on-site every evening and distributes evening medications, all other times trained staff dispense the medications. The RN does complete various trainings with the staff, including medication administration. The shelter began using the Pyxis Med-Station at the end of March 2016. The RN reported most discrepancies produced by the Pyxis Med-Station were staff getting confused with the beginning count versus the actual count. These discrepancies were easily fixed by the RN or the staff member. At the time of the review the shelter had no open discrepancies. The RN prints out and reviews numerous reports at least two times per month from the Knowledge Portal. Some of the reports include: Inventory by Station, All Discrepancies, Inventory Verification, System Statistics, Profile Override, and Console and Station Activity Log.

All youth medication is stored in the Pyxis Med-Station. After the youth’s information is entered into the Pyxis Med-Station, a bin within the machine is assigned to the youth. Each medication is stored in its own separate bin within the Med-Station so topical medications are always stored separately. The youth’s medication is placed in that bin and once it is closed it can only be opened during assigned medication times or for inventory purposes. Staff using the Pyxis Med-Station must enter a password as well as their finger print to gain access. The first drawer of the Pyxis Med-Station is used for topical medications, the second drawer is used for controlled medications, and the third drawer is used for non-controlled medications. The shelter has a system in place for refrigeration of medication if needed; however, there was no medication that required refrigeration during the time of review.

All medications are inventoried at admission when given, by maintaining a perpetual inventory with running balances, and at discharge. All controlled medications are also inventoried each shift by two staff members. The inventories are documented on the back page of the youth’s Medication Record Log (MRL). All non-controlled medications are inventoried at least once per week, by two staff members and documented on the back page of the MRL. All sharps in the shelter are inventoried once per week.

There were four youth in the shelter on medications and those files, as well as, three closed files were reviewed for medication administration. The agency still maintains hard copies of all documents relating to the medication process and enters all information into the Pyxis Med-Station, as required. The youth’s MRL is maintained in a medication binder until the youth is discharged and then the MRL is filed in the youth’s file. All MRLs reviewed, documented the youth’s name, a picture of the youth, allergies, medication the youth was taking with dosage and time to be given, method of administration, side effects/precautions, special procedures/instructions, staff initials, youth initials, full printed name and signature of each staff member who initialed a dosage, and the full name and signature of the youth receiving medication. The back of the MRL documented all daily and weekly inventories and the verification of the medication with the pharmacist or by the RN.

Out of the four youth currently in the shelter, the MRLs documented the youth received medication at the prescribed times except for two youth who both documented a missed dose of medication. These two

instances had already been reported to the CCC and the CCC reports were reviewed. All four files documented that perpetual inventory counts with running balances were being maintained on each youth. Weekly inventories of non-controlled medications were completed. Shift-to-shift inventories of controlled medications were documented.

There were three closed files reviewed for medication administration. All three files documented the youth received medications at prescribed times. Perpetual inventories with running balances were maintained. One file reviewed documented nine instances out of forty-one shifts when a shift-to-shift inventory of a controlled medication was not completed. Weekly inventories were completed for the non-controlled medications.

The shelter has had three CCC reports relating to medication errors in the last six months. One of the reports was in July 2016 and two of the reports were in December 2016. One report was due to an error in the medication inventory, the count was not accurate. This was reported to the CCC. It was unable to be determined how the count became inaccurate. The other two reports were due to missed medications. The two missed doses of medications happened on the same day, on the same shift. Both youth were to receive an evening dose of medication and it was missed. A CCC report was completed, as well as, an internal incident report. The youth's guardians were notified. The Pharmacist was notified and stated there would be no adverse side effects from missing the dose.

Exceptions:

In one file reviewed there were nine instances out of forty-one in which a shift-to-shift inventory of a controlled substance was not completed.

The shelter has had three instances of medication errors reported to the CCC in the last six months.

4.04 Medical/Mental Health Alert Process

Satisfactory Limited Failed

Rating Narrative

The agency has a policy in place for the Medical and Mental Health Alert Process. The policy was last reviewed and updated in November 2016.

Upon admission to the shelter, each youth receives a preliminary medical, mental health, suicide risk, and substance abuse screening. Any conditions are noted on the Intake/Assessment Form. All medication the youth is taking is listed on the Intake/Assessment Form and the Medication Record Log (MRL). Medication allergies, food allergies, and any other allergies are noted on the Intake/Assessment Form, the MRL, and on the spine of the youth's file with "Allergy" checked off and a "Medical/Mental Health Alert" label on the spine with "Allergy" checked there as well. In addition, youth issues, concerns, conditions, or physical restrictions are noted on the youth board in the staff office using appropriate codes. All incoming staff review the youth board at the beginning of each shift.

A review of three open youth files and two closed youth files was conducted to verify the shelter's alert process. All five files documented any applicable alerts on the spine of the youth's file. All medical related information was documented on the Intake/Assessment Form inside the file. All alerts documented on the youth's files corresponded with alerts documented on the alert board in the staff office. Alerts on the board were coded with numbers 1-18, with each number representing a different alert. Staff interviewed were knowledgeable of the alert system.

There were no exceptions to this indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has an Episodic Emergency Care Policy in place. The policy was last reviewed in September 2013.

There are procedures in place for staff to follow in various types of medical emergency situations such as: Skin Wounds, Dental Trauma, Nose Bleeds, Poisons, Convulsions, Seizures, Head Injury, Stings and Bites, Burns and Scalds, and Electrical Burns. The shelter emergency drills simulating these events and other potential situations are to be conducted quarterly on different shifts. There are procedures in place for maintaining first aid kits. All staff in direct contact with youth must be certified in CPR and First Aid.

There have been no off-site emergency care events in the last six months. However, the shelter does have an Emergency and Episodic Care Log in place. The shelter has completed a Medical Emergency Drill on each shift for the last quarter. The drills consisted of a staff heart attack, a fall, and a nose bleed.

First aid kits are located in the staff office and in both the vans. The kits are checked weekly for expiration dates and replenished as needed. The shelter has both a knife for life and wire cutters in the staff office.

A review of a sample of staff training files revealed all ten staff were currently certified in CPR and First Aid.

There were no exceptions noted for this indicator.