



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CDS-Interface NW

on 04/01/2015

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	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

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

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%

Overall Rating Summary

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

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.

Review Team

Members

Keith Carr, Lead Reviewer, Forefront LLC/Florida Network of Youth and Family Services

Elizabeth Hernandez, Program Administrator, ACH of Bay County, Inc.

Patricia Rock, Shelter Services Manager, LSF-Northwest



Quality Improvement Review

CDS-Interface NW - 04/01/2015

Lead Reviewer: Keith Carr

Jason Ishley, Clinical Director Non-Residential Services, CCYS

Catherine St-Vil, Reviewer, Florida Network of Youth and Family Services

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 2 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 1 Clinical Staff | 2 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 1 Food Service Personnel | 7 Other |
| <input type="checkbox"/> DMHA or designee | 0 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 checked="" type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 6 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 6 MH/SA Records |
| <input checked="" type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 6 Personnel Records |
| <input checked="" type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 8 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 15 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 12 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- 4 Youth 6 Direct Care Staff 0 Other

Observations During Review

- | | | |
|---|--|--|
| <input checked="" type="checkbox"/> Admissions | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input type="checkbox"/> Confinement | <input checked="" type="checkbox"/> Program Activities | <input type="checkbox"/> Tool Inventory and Storage |
| <input checked="" type="checkbox"/> Facility and Grounds | <input checked="" type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage |
| <input checked="" type="checkbox"/> First Aid Kit(s) | <input checked="" type="checkbox"/> Searches | <input type="checkbox"/> Transition/Exit Conferences |
| <input checked="" type="checkbox"/> Group | <input checked="" type="checkbox"/> Security Video Tapes | <input checked="" type="checkbox"/> Treatment Team Meetings |
| <input checked="" type="checkbox"/> Meals | <input type="checkbox"/> Sick Call | <input type="checkbox"/> Use of Mechanical Restraints |
| <input type="checkbox"/> Medical Clinic | <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input checked="" 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

There were no Staff Secure cases submitted to the agency in the last year.

Strengths and Innovative Approaches

Rating Narrative

The CDS Interface Youth Program Northwest is a 12 bed facility located in Lake City. The agency experiences very little turnover and has a stable employee base that reflects many of its staff members being employed for more than 10 years.

The agency has skilled experts onsite related to counseling. They are fortunate to have access to two (2) Licensed Mental Health Counselor to service this region. Stephanie Douglas, LMHC was the sole licensed personnel for this region and provided the clinical supervision to Lindsey Morton. In January of 2015, Lindsey Morton also received her license LMHC.

The agency has been focused on increasing shelter utilization. They have been experimenting with longer stays, from 21 to up to 35 days. They have also been utilizing the 48 hour furlough stipulated in their current contract. This has proven useful in the longer stays to allow a youth to go home for a night or two without having to complete a new intake. They are hopeful that the furloughs will enhance shelter successes and program completion.

Standard 1: Management Accountability

Overview

Narrative

CDS Family and Behavioral Health Services, Inc. – Interface Youth Program Northwest provides both residential and non-residential programs. This program site is located at 1884 Southwest Grandview Street in Lake City, Florida. CDS-Northwest provides services through a direct local service provider contract with the Florida Network of Youth and Family Services (FNYFS). The CDS-NW agency primarily provides CINS/FINS services in Columbia, Dixie, Hamilton, Lafayette and Suwannee Counties. CDS-NW also operates other Residential and Non-Residential programs in Gainesville and Palatka, Florida respectively. All three (3) program locations report to the agency's Chief Executive Officer and Chief Operations Officer that are located in the central office in Gainesville, Florida.

The CDS-NW in Lake City, Florida location is operated by two (2) Regional Coordinators. The Regional Coordinator position is the highest ranking position for the agency at this location. The agency assigns the daily operation and direct responsibility of each shelter to the Regional Coordinator at each youth shelter. The agency also has Licensed Clinicians, Residential and Non-Residential counselors, Residential Direct Care and Non-Residential staff members.

The agency has a Centralized Human Resources and fiscal departments that handle all personnel and financial matters. Each area program has a licensed clinician that oversees and review all youth that have suicide risk issues. Each program also provides general counseling and mental health services to youth and families. These services are delivered at their respective location. All CDS residential shelters and Non-Residential programs have implemented uniform operating protocols for all three (3) service locations in their respective service areas. Other uniform protocols for all 3 locations include training and professional development exercises.

The CDS-NW program agency conducts screenings prior to hiring of all staff members. All staff members receive training at their respective service locations. In addition, the agency consolidates trainings to simultaneously train its staff on various training topics across all work sites and to create better camaraderie amongst staff members assigned to various youth shelter locations.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency provided evidence of a background screening policy. The current policy is titled P-1025 Background Check, Reference Check, Fingerprinting for Personnel, Volunteers or Interns. The agency last reviewed this policy in January 2014. The agency provided documentation of a copy of the DJJ Inspector General's Office Annual Affidavit of Compliance with Level 2 Screening Standards. This affidavit was submitted by the agency on January 23, 2015.

A review of a total of six (6) CDS staff members listed on the current roster were identified as being eligible for background screenign prior to hire and or a 5 year rescreening. Of these staff files, 5 were new hire background screenings and one was a 5 year rescreening.

Of the new hire files reviewed, all 5 new hire files included documentation verifying that the background screening was completed as required. Five (5) out of six (6) client files met all requierements of the indicator.

There is one exception noted for this indicator. The 5 year rescreening completed for staff member W. Disbrow was submitted on 09/23/2014 and completed on 09/25/2014. These dates reflect that the background screening was completed after the 09/20 date of hire. This reviewer informed the agency of the date and informed the agency that they could begin rescreenings as early as 6-12 months in advance to reduce missing any rescreening dates in the future.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has several policies that address staff awareness and the agency's efforts to maintain an environment that supports a safe and non-harmful environment for the youth and families that they serve. The agency utilizes a combination of policies to support an approach in its programs that promotes the Provision of an Abuse Free Environment that include Standards of Conduct P-1212; Behavioral Expectations for Staff P-1032; Rule Violations P-1128; and Florida Abuse Reporting P-1044.

A review of six (6) DJJ CCC incidents reported and accepted by the Department in the last six (6) months were reviewed. In addition, a total of forty-six (46) client Unusual Event Reports (Internal) Documents were reviewed on site. Of the DJJ CC incidents, none involved circumstances that related to the agency and or staff member making youth, staff and others feel unsafe/unsecure or subject to any threats and any form of

abuse or harassment.

All CDS NW staff members available on site completed the QI Staff Survey. Results from the survey indicate a total of six (6) Direct Care Staff members were surveyed online during the onsite program review. These staff members were surveyed and asked in the past year, how have the working conditions been at this shelter. Three (3) staff members reported Very Good and three (3) Good when responding to this question. All 6 staff members stated that they have not observed a co-worker telling a youth that they could not call the Abuse Hotline. A total of 6 staff members reported No that they have never observed a co-worker using profanity when speaking to youth. All 6 staff members reported that they have never observed a co-worker using threats, intimidation, or humiliation when interacting with the youth. All 6 staff members reported that they have never witness any youth being sent to their room or an isolation room for punishment.

All CINS/FINS residents were available on site completed the Quality Improvement Youth Survey. Results from the survey indicate a total of four (4) youth were surveyed on site during this program review. All 4 reported that they did know about the abuse hotline available for youth to report abuse at this shelter. In addition, none reported having made an attempt to call the abuse hotline. All 4 youth reported that adults at the facility were respectful when talking with them and other youth. Three report No, and 1 reported Yes to hearing adults use curse words when speaking with you or other youth. The yes response was listed as an unidentified staff member. None of the residents surveyed reported having heard any adults threaten them or other youth. All 4 reported feeling safe at this shelter.

The agency also reported 3 staff members that are no longer employed with the agency. None of the employees no longer with the agency left for issues related to violations to maintaining a non-abusive environment.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

A review of six (6) DJJ CCC incidents reported and accepted by the Department in the last six (6) months were reviewed. In addition, a total of forty-six (6) client Unusual Event Reports - Internal Documents were reviewed on site. In addition, the agency provided an Unusual Event Binder with all more than forty (40) events documented.

Incidents reported appear to fall within the range of normal occurrences in a facility of this type. The most frequently occurring incident was runaways, contraband, and facility issues. Each instance was handled appropriately. Parents were notified and investigations were conducted, as appropriate.

Incidents involving suicidal ideation were handled appropriately with sight and sound placement and close monitoring by staff. Baker Act cases were conducted and completed on a case-by-case basis and as each situation warranted it.

The Incident Report binder contained other items called Unusual Events, which included facility maintenance items. Staff related incidents are also addressed as required. The majority of all reporting times to the DJJ CCC are all under the 2 hour reporting requirement.

Staff members interviewed were very familiar with Incident Report policy and reported no issues with the process.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place that addresses the requirements of this Training indicator. The reviewer assigned to this indicator, reviewed eight (8) staff training files (Three, first year hire, five over one year). The program maintains an individual training file for each staff and an employee training plan form that tracks the type of training and number of hours accumulated. Certificates, sign-in sheets, and pre/post test are included in each staff member's training file.

A review of first year training was conducted. In review of eight (8) staff files, three (3) new staff members (Youth Care Workers) that met requirements of the indicator with 80 hours plus. A staff member hired 10/21/13, does not have CINS/FINS Core Training, Title IV-E Procedures and Fire Safety Equipment, but had evidence of Fire Detection, and Hazard training. Staff hired 9/30/13, does not have Fire Safety Equipment but does have Fire Safety Detection, Hazard and Safety.

A review of Annual training was conducted. In review of eight (8) staff files, five (5) staff members (Youth Care Worker) with the agency for over one year, met requirements of the indicator with 40 hours plus. Four of the five staff received training in Fire Safety Equipment, Crisis Intervention Skills and Universal Precautions (Infection Control). All 5 staff received other various training required by the agency to include additional training outlined in the indicator.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program collects and analyzes information on a monthly, quarterly, and annual basis in order to maintain quality assurance and an effective method of practice. Information pertaining staff and client satisfaction surveys, meeting minutes, and outcome and output reports are aggregated and reviewed among the administrators.

CDS is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). As this writer is writing, they are in the midst of evaluation to get accreditation for another three years. CARF is conducting a review of CDS's internal program and operational reports to assess effectiveness in prevention, residential, and independent living structures.

The CINS/FINS peer review of sampled client case files are conducted by non-residential staff among all the CDS sites (Northwest, Central, and East), usually located at CDS NW. Two quarterly reviews have been conducted so far for the 2014-2015 year. The first quarterly review contained six files from CDS NW. Each indicator for all files were rated as "yes" for completion. Indicators reviewed included screening and intake process, psychosocial assessment, case/service plan, case management and service delivery, counseling services, adjudication/petition process, and youth records. There were no noted CDS NW files for the second quarterly reviews that were peer reviewed.

The program regularly updates needed forms and policies and procedures throughout the year as needed. From February 1, 2014 to February 6, 2015 there has been over 70 forms that were revised for the program intranet and over 50 revisions to policies and procedures manual. This demonstrates that improvements are possible and therefore implemented; making the program work as effectively as possible.

There has been eight (8) CINS/FINS managers meetings in the last six months. The respective meeting minutes were reviewed. Meeting minutes explained the various topics that were discussed regarding the efficiency and consistency of the programs in CDS NW, Central, and East. Topics such as electronic communications, brainstorming to increase client participation, and the updating of different forms. For instance, a specific issue observed involved low statistics for certain months and the change of contractual agreement with FNYFS regarding client statistics. Of the eight meetings, five meetings involved discussion of brainstorming methods to reach out to youth that may need program services. Within five months, this issue has been improved. This demonstrates the consistent review of policies and the implementation of risk management strategies to decrease potential threats to the program.

CDS generated a risk management five year plan (2013-2018) that addresses eleven program components that should be focused on to increase program efficiency. The areas include: maintain incorporation status; maintain and active Board of Directors; reduce risks and liabilities related to personnel issues; ensure compliance with Florida Statutes, rules, program rules, and contract management requirements; reduce financial risks and liabilities; reduce information technology risks and liabilities; reduce environmental risks and liabilities; reduce travel and transportation risks and liabilities; reduce risks and liabilities resulting from emergency situations; reduce risk and liabilities related to working with volunteers; and maintain adequate liability insurance. These areas were described and analyzed carefully. An annual review of this was conducted. In fact another meeting and publication was generated for year two. The refocus on this review included topics like policy and procedures, increasing outreach efforts and clients, and decreasing medication errors. This indicates that continual evaluation amongst the programs are crucial to executing an effective program.

Monthly reviews of incidents and accidents are conducted. There is an incident summary report that was created that contains information regarding clients and staff. The incident categories that are relevant to this certain agency include runaways, maintenance, computer, law enforcement, medication errors, outside medical, and client physical fight. Incident summary reports were reviewed for the past two years and shows a significant decrease in the number of these activities.

CDS's CINS/FINS Performance Report generated monthly also displays the aggregated outputs and outcomes for residential and non-residential services. Outputs and outcomes information is based on contract requirement indicators. The findings are discussed and assessed in their monthly CINS/FINS managers meeting and then communicated to the rest of staff to ensure knowledge consistency. As noted from the meeting minutes, trends are addressed and respective change is implemented such as increased outreach and assurance of completion of intakes.

Customer satisfaction data is reviewed on a monthly basis.

Employee and community stakeholder and business surveys are conducted every other year.

Constant evaluation is conducted for CDS in monthly CINS/FINS meetings and executive manager meetings as well as annual meetings that include community partners, all staff, executives, the board, and community. Strengths and weaknesses are consistently identified and improvements are implemented with all staff informed throughout the process.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The program provides counseling and case management services via their Interface residential program, as well as the Family Action non-residential program. Services are being provided residentially by one clinician (non-licensed), and two clinicians (licensed) non-residentially. The residential counselor provides services on-site at the Interface program. The non-residential counselors provide services in the family's home, a local community space, or in the counselor's office. There is currently one vacancy for the Hamilton County counselor position, and the program supervisor reports difficulty keeping the position filled. All clinical staff and supervisors reviewed show solid understanding of program expectations and are conscientious about service delivery and meeting contractual standards.

The non-residential Counseling Program provides non-residential services for youth and their families in primarily Columbia, Suwannee, and Hamilton Counties. The non-residential component consists of a one (1) Family Action Senior Counselor/Manager and one (1) Family Action Counselor Case Manager. The agency also has 1 Residential Counselor that primarily provides counseling services to the residential program.

Outreach for counseling service are provided to group or individual presentations are conducted every month. These outreach areas include schools, school resources officers and law enforcement, courts, doctor's offices and community events. The agency also sends the Senior Counselor/Case Manager to participate and attend the DJJ Circuit 3 Advisory Committee. The agency is considering group counseling in schools in the future.

The agency also leads and coordinates the local Case Staffing Committee, a statutorily-mandated committee that develops a treatment plans for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court if needed.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure that matches the quality improvement standard. Requests for services come through a centralized location and a determination is made quickly regarding placement residentially, or non-residentially.

A total of 8 files were reviewed for this standard. 4 files were chosen randomly from each program, and contained 2 open and 2 closed files. Each file contained a comprehensive screening with pertinent information regarding a description of the crisis, eligibility criteria, demographic and background information, assessment of areas of risk, and a determination regarding immediate youth and family needs.

In each file reviewed the screening was completed within 7 days of the referral (when applicable). The program's policy is to complete an intake within 7 days of screening, and nearly every case an intake was scheduled (and occurred) the same day as the screening.

Each file has evidence of parents/guardians and youth receiving written information of available service options, right and responsibilities of all parties involved, the parent guide to CINS/FINS services, possible actions occurring through involvement with CINS/FINS services, and grievance procedures.

The reviewer documented no exceptions to this indicator.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure that matches the quality improvement standard. Needs assessments are used by the residential and non-residential programs to gather information for the individual case plans. It is noted the programs use different versions of the needs assessment based upon the requirement from DJJ to utilize the PAT (prevention assessment tool).

A total of eight (8) files were reviewed for this standard. A total of four (4) files were chosen randomly from each program, and contained two (2)

open and 2 closed files. Each file contained a needs assessment that gathered information across all the required domains, and was then concisely summarized by the clinician.

In the four (4) residential files reviewed, the Needs assessment was initiated within 72 hours of admission to the program. In three of the four files the Needs assessment was completed the same day as admission to the program. In the four non-residential files reviewed, the Needs assessment was completed within the first three face-to-face contacts. In all cases reviewed, the Needs assessment was completed the same day as admission to the program.

In all the files reviewed the Needs assessment was completed by a master's level clinician, and the summary was signed by a supervisor. In the instance of a suicide-risk assessment being completed it was reviewed, and signed, by a licensed clinician.

The reviewer noted no exceptions for this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure that matches the quality improvement Case/Service Plan Standard. Individual Service plans are used residentially and non-residentially as a means of identifying the interventions needed to assist the youth and family in achieving their goals. The plans reviewed also incorporated the unique needs, strengths, abilities, preferences, and challenges of each youth and family member.

A total of eight (8) files were reviewed to assess the agency's adherence for this indicator. A total of four (4) files were chosen randomly from each program, and contained two (2) open and 2 closed files. Each client file contained an individual plan that had been developed within 7 days of completion of the needs assessment. It was clear the goals for each youth and family were tailored to the specific needs of the family, as well as from information received during the screening and Needs assessment.

Individual plans contained prioritized goals for treatment, achievable objectives for each goal, and identified persons responsible for working toward the goals. They also clearly identified the type of service needed, frequency, location, initial date of creation, target date for completion, and actual date of completion for every goal. All individual plans reviewed had signatures of the youth, parent/guardian, counselor, and supervisor. When applicable, the individual plans were reviewed every 30, 60, and 90 days with the youth and parent to assess the level of progress towards agreed-upon goals, determine the need to terminate the case, discontinue goals, or make amendments to the plan.

No exceptions to this indicator were noted.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure that matches the Case Management and Service Delivery requirements for this indicator. Counselors within the residential and non-residential programs strive to deliver services to each family in a way that meets their unique problems and needs. A total of eight (8) client files were reviewed for this standard. A total of four (4) files were chosen randomly from each program, and contained 2 open and 2 closed files.

Each file reviewed had a counselor assigned at the initial intake session. As applicable, the counselors coordinated referrals to external service providers based upon the ongoing assessment of the youth and family's needs. In every case the counselor coordinated implementation of the service plan, monitored the youth and family's progress towards goals, and provided support to the family as a whole. As necessary, referrals were made for intervention to the case staffing committee. In all the files reviewed there was evidence of continued case monitoring, case termination, and follow-up. Counselors actively involve youth and parents during the discharge process which includes review of progress towards goals, aftercare options, and referrals for additional support.

Through interviews with clinical staff it was evident regular, ongoing communication exists with the youth and parent in regard to the services they receive. Files showed attempts by counselors at contacting parents at least once per week.

No exceptions to this indicator were noted.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure that matches the quality improvement standard for this indicator. A total of 8 files were reviewed for this standard. There were 4 files that were chosen randomly from each program, and contained 2 open and 2 closed files. Residential counselors provide individual, family, and group counseling. Non-Residential counselors provide individual and family counseling, and do so in the participant's home, a community location, or the counselor's office.

In all the files reviewed it was observed that youth and families were receiving services in accordance with the individual plan. Presenting problems reported at the screening were found to be addressed in the needs assessment, service plan (and reviews), referrals, case management, and during discharge.

Residentially, the counselor's standard practice appeared to be to have three individual sessions per week with the youth, one family session per week, and five group sessions. This practice was observed across all the residential files reviewed. Non-residentially, the counselor's made attempts to meet with youth and/or family's weekly. There was evidence of regular communication with a parent/guardian when the intervention focused primarily on the youth. Counselors in both programs maintained accurate chronological case notes on youth and family progress. All files reviewed adhered to laws regarding confidentiality. The program conducts quarterly files reviews to ensure records are meeting standards, addressing youth needs, and to also identify methods of improving service delivery.

No exceptions were found for this indicator.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure that matches the quality improvement standard for this indicator. One file was reviewed for the adjudication/petition process. The record shows adherence to the minimum timeframes for notifying case staffing committee members about the date/time of the meeting. Case staffing committee forms showed regular representation from the Department of Juvenile Justice, school officials, and other community members. Recommendations of the case staffing committee were documented thoroughly and copies of the documentaion were provided to the family either at the meeting, or mailed to them if not present. The case did not go to petition so no summary was completed.

The reviewer notes no exceptions to this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has placed into practice the marking of all client files as "confidential." With the exception of one file out of 14 closed and open records, one was not marked as so.

Records are all kept in a safe location and only available to agency staff. Open files are kept in the youth care worker office on shelf while a worker is present. When not present, it is locked in a cabinet.

Recently closed files are locked in another secure office. As files accumulate, they are transported to the Gainesville site.

Youth records are maintained in a neat. Handwriting is legible. Open cases contain dividers that divide by major topics such as behavior and health and are kept in an orderly manner. Closed files (with the exception of one reviewed) do not contain dividers.

The reviewer notes no exceptions to this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The CDS IYP-NW youth shelter is located in Lake City, Florida in Columbia County. The facility operates twenty-four hours per day, seven days per week and is licensed by the Department of Children and Families for twelve (12) beds. The agency serves both CINS/FINS and DCF program participants. At the time of the quality improvement review, there were a total of four (4) youth in the shelter. The shelter is comprised of a detached single building that has separate split floor plan design with female and male sides of the facility.

CDS NW staff members are primarily responsible for completing all screening, intake and paperwork. These staff members are also responsible for orientation and providing necessary supervision and general assistance. The shelter's direct care staff members are trained to provide the following services including the youth screenings; medication administration; health, mental health and substance abuse screenings; first aid; cardio pulmonary resuscitation (CPR); and case specific referrals. The supervisory and counseling staff members receive referrals and monitor service delivery on a consistent and on-going basis. The medication and first aid supplies are stored in the staff office in a locked desk behind a locked door near the dining/office area. The Direct Care Worker staff offices are located inside the youth shelter adjacent to the day room. The residential shelter also includes administrative offices for Regional Coordinators, Counselors and Case Managers and the Administrative Specialist.

Residential services, including individual, family, and group services, are provided to youth and families. Case management and substance abuse prevention education are also offered. The program also has an effective grievance process. When submitted grievances are reported, they are addressed within twenty-four hours of being submitted to management.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

At the time of this review, the program's Health and fire safety inspections are current. Both inspections are as recent as January 2015. The Health inspection was scored as Satisfactory with no additional comments or instructions made by the Department of Health at the time of inspection. The Fire Safety Inspection indicated no violations during the visit. The program completes a minimum of 1 fire drill per shift per month. All fire drills are logged, as well as documented on monthly calendar. All fire drills are 2 minutes or less as is required. Fire drills are all kept in a binder. The Fire Drill binder was very neatly organized with dividers making the process easier to review. The agency has a disaster plan that is updated annually. Plan includes all components consistent with FNYFS policy and procedure manual. The program completes 1 mock emergency drill per quarter. Drills are documented and maintained in a file. Drills are all then kept in a binder that was provided to this reviewer when requested. The agency's Mock emergency drills were reviewed for the most recent quarter. The program completed a drill on 01.28.15 and all areas were documented. The evening shift drill was completed in the month of January does not indicate what date it was completed on (01/15 or 01/16). All other areas are documented. Night shift drills completed in January do not indicate what date they were completed on (01/21 or 01/22). In addition, they are missing time/duration to exit building. The facility is equipped with a knife for life that is located in YCW office. The knife for life is kept in unlocked drawer however, office door is secured and locked. The knife for life is accessible by all the staff on shift. Menus are posted and approved by a licensed dietician. The Kitchen very organized. All cold food is stored properly the and pantry area is clean. The program has a current DCF Care License that is displayed for all to view in plain sight.

The building is locked and secure. All doors are secure in and out, access is limited to staff members. The youth cannot access staff only areas. Key control is in compliance with regards to keys being secured in a locked box that only staff members can access. During the walk through, the reviewer was able to observe a detailed map and egress plans of all areas of the facility. The Abuse Hotline information/phone number was posted throughout the facility in plain view, as well as DJJ Incident Reporting number. The reviewer observed cameras throughout the facility. All cameras were operational at this time and facility had two (2) areas in which camera feed could be monitored, both monitors were in working condition. Interior and exterior lighting appeared to be in working condition, areas are clean with no signs of infestation. Furniture appeared to be in good condition. No observation of graffiti was detected. The reviewer observed some personalization in the common areas with gender specific themes. All youth have individual beds assigned, rooms were observed to be in neat, clean orderly condition. Beds have specific numbers assigned for classification purposes. Interior areas (bedrooms, bathrooms and common areas) are all organized. No observation of contraband or other unauthorized materials/objects. Participants are separated by gender and have their own assigned bathroom/living room areas. Both boys and girls areas/bedrooms were very clean and organized including bathroom and shower areas. Everything appeared to be in good working condition. Washer/dryer are operational. The program shared that they recently received funds to purchase new a washer/dryer and stove.

Exterior areas are free from debris, no hazards, well maintained and dumpster/trash cans are covered. Agency vehicle was locked at the time of review. The reviewer was able to observe major safety equipment including a first aid kit, fire extinguisher, flash light, glass breaker and seat belt cutter. The agency van did not contain the most up to date insurance card when inspection was conducted however, it was provided immediately following the inspection. Most recent card was also placed in the van at this time. The agency staff members do not transport youth/clients in their personal vehicles. All chemicals are listed, approved for use, inventoried and stored securely. The Material Safety Data Sheets (MSDS) are maintained on each item. The program has a posted grievance procedure that provides youth with clear, accessible, and fair avenues for lodging and resolving complaints and grievances within the required timeframe, including opportunity for appeal. The program has a grievance policy stating that grievances/complaints will be addressed within 72 hours. It was not clear in their procedures that they were

maintaining grievances for up to one year, though they did have grievances that were older than the 6 months this review was to cover. The reviewer discussed grievance practice with YCW and it was explained that the youth fill out the Grievance and it is then handed to a staff member. The program reported that there were no grievances submitted in the last 6 months, therefore this reviewer was not able to review the practice of addressing/resolving grievance from start to finish. The program has posted daily/weekly schedule(school), daily/weekly schedule(summer), as well as a calendar that is developed for summer months detailing the activities that are available for the participants each day. The program also has a list of approved activities that staff/youth can choose from for weekends during the school year. Activities include social, recreational and educational activities, as well as treatment related activities. Youth are also provided the opportunity to participate in faith based activities.

Exceptions are noted for this indicator. Mock emergency drills were reviewed for the most recent quarter. The program completed a drill on 01/28/15 and all areas were documented. The evening shift drill completed in the month of January does not indicate what date it was completed on (01/15 or 01/16) all other areas documented. The night shift drill completed in January does not indicate what date it was completed on (01/21 or 01/22). It was also missing time/duration to exit building. The vehicle inspection completed with no major exceptions noted. Additionally, the van did not contain the most recent insurance card however, was provided immediately and placed in the van by YCW.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The agency reviewed three (3) open files and two (2) closed files. The program completes a participant orientation upon the date of intake (within 24 hours). Orientation Checklist identifies areas to be addressed by staff at the time of intake. Youth are provided information that includes key staff and their roles. Review of evacuation procedures to include a tour of the facility. Staff reviews procedures to access medical, dental, mental health care and/or substance abuse. During orientation youth are informed of their rights, grievance process and access to the Florida Abuse Hotline. Visitation policy, telephone procedures, dress code, program goals and services are also addressed during intake/orientation. Youth are provided with Participant Orientation Packet for which they acknowledge receipt and understanding evidenced by signature page in the youth file. Orientation includes suicide prevention. Of the files reviewed no alerts were made due to there being no concerns at the time of intake. One open file Screening Health Addendum was not completed. One closed file Screening Health Addendum was incomplete. The Closed files for 2 clients reviewed for Program Orientation indicator 3.02. Files contained intake/orientation paperwork. There was no table of contents in the file which made it difficult to review. Files did contain all of the information that was provided to the youth at the time of intake. Parent and youth signatures were obtained and acknowledgement of participant orientation packet was documented by parent and youth.

Some exceptions are noted. In review of a youth file, a checklist requires initials to confirm that information was discussed/provided to the youth. Staff initialed and drew a line through the rest. The form has individual lines for staff to initial each area as they review/provide the information to the participant. A review of 2 closed files and 3 open files Information Checklist for parents indicates that all areas discussed with parent should be checked. No check marks were observed in either file. Staff signature on page indicating the review but, this reviewer could not identify what information was reviewed with the parent. No checks. Closed file for one resident did not have a NETMIS Face sheet. The Face sheet was found in file. No table of contents were found for a closed file, therefore the reviewer could not determine what should be found in the completed closed file. The Orientation checklist for 2 clients also have a line drawn through instead of initialed by staff at the time of intake.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a detailed policy that meets the requirements of the indicator. The agency as a process in place in order to determine room/bed assignment. A review of three (3) open files and 2 closed files. Initial classification and room assignment are completed during the orientation process and within 24 hours. The program has a process for room assignment that assists with appropriate classification/room assignment. Areas considered include age, gender, youth's history and exposure to trauma. Initial interactions, level of youth's cooperation at the time of intake, as well as initial staff observation of the youth are all factors during the process of assigning a room/bed. Program gathers information with regards to gang affiliation, suicide risk and sexually aggressive reactive behavior also when considering a youth's room assignment.

No exceptions are noted for this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy with regards to maintaining log books. The policy includes guidelines that shall be followed. The agency policy includes all areas as required by standard 3 indicator 3.04 Logbooks.

In review of the professional log book, it is designed to accommodate all that is required of the indicator. It has sequential pages that allows staff to document daily security and safety of the youth (i.e. Dates, times of incidents, events or activity, names of youth and staff involved, pertinent information and signature of recorder).

The reviewer found that the book was excellent in documenting specifics that is helpful to minimize and/or eliminate error of responsibility on shift (i.e. Program reminders in front of book, pages designated to outline date, shift, times, shift lead, key exchange, staff on duty and participants in or out of shelter, and who has read the log; pages designated for chronological shift events and shift lead summary/comments at the end of the day).

The program YCW and Coordinator reviews the books daily and weekly, indicating it has been read and documenting awareness of occurrences. The books are read by YCW for the previous two shifts at a minimum to be aware of occurrences. All entries are documented in ink. This log indicates consistent program reminders through to help staff with a smooth flow of shift. Observed no erasers or white out areas in the log. A shift lead is decided on each shift to assure all pertinent responsibilities are completed by all assigned to the shift.

A minor exception was noted. The observation of the log book indicated very minor areas where errors were scratched and no initials for corrections. Some entries were not struck through with a single lline or initialed with date of correction.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The program has a written description of the behavioral management strategies utilized for it's participants. The plan is very clear as to how youth are able to earn points/privileges. Plan discusses the system and how each step is earned. Plan encourages staff to use positive feedback when addressing youth behaviors and applying successful interventions. Rule violations are clearly addressed in the BMS as well as the consequences for failure to follow the rules.

The BMS encourages youth to demonstrate pro-social behavior and provides progressive levels for youth to achieve. Achievement of different milestones result in increased privileges/activities for the youth. Each level of the programs BMS system promotes skill building and encourages advancement/achievement of the next level. Points are documented and tracked daily on the participants Point Sheet. As points are assessed (positive or negative), staff are to provide feedback to each participant on why points are earned and ways to improve when youth has earned negative points. The BMS indicates that there will be no group punishment for the actions of an individual. The BMS provides staff with examples of inappropriate consequences, which may subject staff corrective action up to and including termination. BMS does not allow for youth to impose disciplinary sanctions on other youth. Youth are introduced to the BMS during the orientation process. This introduction includes the program rules, ther response/consequences to violating rules and the FACE System, which includes points and level. Each youth is provided with a copy of the BMS to keep in their possession.

This reviewer was able to speak face to face with YCW who was able to verbalize the Behavior Management Strategy utilized by the program. She appeared to be very familiar with the system and was able to speak about it in detail. YCW provided visual examples of the "point" system and spoke about the BMS in a positive manner. YCW expressed that youth utilize the system on a daily basis and are well informed as to how the system enhances their time while here at the program. The BMS encourages focusing on targeted skills that include life and social skills development. YCW explained that the targeted skills selected initially are individualized by youth as of a result of the orientation and assessment process. Staff is provided with ongoing training with regards to the BMS in order to ensure it is understood and being applied fair and consistently by all staff. Each staff receives a handbook that details the Behavior Management Strategy used by the program. Staff receives feedback from Shift Leads periodically as to the application of the BMS. Staff appear to be very invested in the BMS and when interviewing the YCW they are very comfortable with being able to teach the youth in how the system works.

There were no exceptions noted at this time for 3.05 indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place that meets general staffing ratio requirements. Policy requires that the minimum staffing ratio is maintained as required by the Florida Administrative Code. The 1 staff to 6 youth durng awake hours and community events. The 1 staff to 12 youth during the sleep period, with at least one staff on duty of the same gender of the youth. Saff schedule was provided to this reviewer and it was noted that at times there are same gender staff on duty. Speaking with YCW it was shared that every effort is made to schedule male/female ratio however,

due to applicant pool the program often has more female staff than male staff.

In observation of the professional log books, staff board and printed schedule, the program maintains general staff ratio requirements, however, not always possible to maintain same gender as the youth on shift, due to availability of male applicants. There is no documented proof of recruiting male applicants, however, the program advertises, do background screenings, word of mouth from staff and through outreach events. The staff schedule is provided to staff and posted in a place visible (i.e. erase board and printed schedule). There is a list of staff with phone numbers to contact in the event a need for additional coverage. There are surveillance cameras well positioned and backup tape 10 days plus, based on the recording activity of the camera, which shortens or lengthens number of days available for review. Staff are documenting bedchecks every 15 minutes via POSX Scanner. A print out is run after the end of each shift.

The program consistently maintains proper staff ratio for client supervision (i.e. 1:6 wake, and 1:12 sleep period), however, not always able to staff a male on each shift, due to limited male applicants and male availability if call-outs per interview with program staff. There is no documented proof of recruiting male applicants, however, the program advertises, does background screenings, word of mouth from staff and through outreach events. Observation of the staff schedule indicates that during overnight shift, two staff are always present. Very few times observed on the staff schedule where no male staff was available for shift. Surveillance cameras are utilized, however, the number of days captured may be limited due to the amount of recording activity within a day.

One exception is noted. The consistent staffing of male staff members is an on-going challenge for the agency. The local agency must provide documented proof of recruiting male applicants on an on-going and consistent basis.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The program has practice, staffing and programming in place to provide programming for Special Population assigned to the program. The program has Staff Secure policy that includes youth only being accepted if they meet the legal requirements of F.S. 984.12 for being formally court ordered in to Staff Secure Services. The program reports onsite that is has not had any category of Special Poputlation cases (Staff Secure, Domestic Violence or Probation Respite) in the 6 months or since the last onsite QI review was conducted. The program has a practice, staffing and programming in place regarding Domestic Violence Respite. The program has written policy in place regarding Domestic Violence Respite. The program has not had any cases in the last 6 months or since the last onsite QI review was conducted.

No exceptions noted at the time of this review.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The CDS-NW program has specific 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 if available. Staff on duty at the time of admission immediately identifies youth that are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The Regional Coordinators and or Licensed Clinicians are

notified immediately if risks and alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. The agency has two (2) Counselors that are Licensed Mental Health Clinicians (LMHC). In addition, the agency's Chief Operation Officer is also a Licensed Mental Health Counselor.

The program has a list of staff members that are authorized to distribute medication. The agency ensures that a staff member approved to provide medication is scheduled on each shift. 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 policy and procedures in place for the healthcare admission screening. The program performs a preliminary physical health screening for each youth using the intake assessment/NETMIS form (section 1 of client file). Information pertaining to observation for evidence of illness, injury, and physical appearance are located on page 1. Allergies information; restrictions information; and general physical health screening questions are listed on page 4. Of the six files reviewed (4 open and 2 closed), all files indicated that all questions regarding health were addressed and were fully completed, when applicable. All questions were asked on the day of intake which indicates preparation of any health concerns were in place.

All the files also included a medical log for individuals under any use of medication. Daily notes are maintained and weekly reviews are completed and signed for by designee. Of the six files, only 1 file had a medical follow-up form for a condition. This is noted in the health section of client file.

The health section contains parent consent regarding medication for all files. The section also notes "if applicable, it will also contain medication transfer, medication logs, medical health follow-up form, special diet reminder, suicide assessment, youth safety agreement, and allergy alert information." There is also a board clearly visible by staff that displays medication information for each youth (as applicable).

No exceptions are noted for this indicator.

4.02 Suicide Prevention

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a detailed suicide prevention policy in place. The agency policies related to this indicator includes Suicide Assessment and the Suicide Assessment Form and Observation Log. The current policy requires that all residents admitted to the shelter be screened during the intake process. The agency uses a customized form that includes questions from the CINS/FINS Intake Form that has been reviewed and approved by the Florida Network. The form is an extended 12 page client intake packet that includes suicide risk screening. This document is primarily completed by the Direct Care staff to screen for mental health screening, suicide risk screening, and an initial substance use. All direct care staff are trained to complete this process with the agency's intake packet. All residential and nonresidential counselors are Masters Level.

Two (2) staff are licensed Mental Health Professionals. The agency did provide evidence of current counseling licenses in effect for the supervising clinician and counselors during the on site program review.

A review of six (6) suicide assessment cases were conducted by the reviewer to determine if the agency's current suicide assessment and prevention practices meet the requirements of the Suicide Prevention indicator. All cases are a sample from supervision cases in the last six (6) months that have been placed on elevated or sight and sound supervision. All cases had confirmed evidence that all residents were screened suicide risk during the initial intake and screening process. All suicide screening results in all cases were reviewed and signed by a supervisor and documented in case notes. All 6 cases had qualifying circumstances that resulted in them being properly placed on sight and sound supervision until an assessment was conducted by a licensed Counselor or an un-licensed Counselor under the direct supervision of a licensed

professional. Based on the results of the suicide risk assessment, all cases indicate that each case was placed on the correct level of supervision. The supervision level that each youth was placed on was not changed/reduced until a licensed professional, or a non-licensed counselor under the supervision of a licensed professional.

The agency has a partnership with the local mental health facility Meridian Behavioral Health. All current counseling staff have extensive experience in completing needs assessments according to FNYFS policy and valid licensed mental health counseling credentials.

An exception was noted for this indicator. Some observation logs are missing some initials on the log form that are not being consistently documented. Specifically, the staff is documenting the time, the behavior, but not documenting the staff making the notation at that time. All other areas are documented and signed as required.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

CDS has a detailed policy that is specified for Medication. The current policy is called Medication Provision, Storage, Access, Inventory, and Disposal. The policy addresses prescription medication, verification of medication, medication provision, supervision, and monitoring, medication distribution away from the shelter, medication errors and refusals, new prescriptions, medication storage, access to medication, inventory procedures, medication counting procedures, discharge of youth with medication, and disposal. In addition, the policy addresses requirements outlined in the DJJ Health Services Manual. The shelter provided a current Memo dated January 26, 2015, that lists a total of thirteen (13) CDS-NW staff that have been trained and are authorized to distribute assistance in the self-administration of their medication for the fiscal year 2014-2015.

This reviewer conducted observations of current medication storage practices. These observations revealed that medications are currently being stored in a locked cabinet, inside a locked box, in a locked closet. The locked room where medications are stored is accessible only to staff members with a key. Each medication is stored in individual zip lock bag with the youths name on the bag. The agency uses a separate self-sealing plastic box with the resident's name on it for all topical medications. At the time of the review, the shelter had one (1) CINS/FINS youth currently on oral medications. The agency has a dedicated pad-locked refrigerator located in the Direct Care Staff Office medications requiring refrigeration. At the time of the review there were no medications requiring refrigeration. The shelter does not provide over-the-counter (OTC) medications, unless the OTCs are prescribed by a doctor.

The policy also requires that staff members must follow measures/steps to ensure that all medication entering the shelter originate from a licensed pharmacy. The policy addresses that all medications that enter the facility with a resident admitted to the program must be accompanied by a doctor's prescription. Documentation of the verification process is captured on page 2 of the Medication Record Log (MRL). The Verification section on the MRL included the actual date that the verification was conducted, the time it was completed, the amount received, and the staff member that completed the process.

The shelter also keeps a supply of sharps in the locked cabinet, in an aluminum box. The sharps include 3 large scissors, twelve (12) children's scissors and two (2) medical scissors in the first aid kits. Per the agency's Regional Coordinator, there were no razors in the shelter at the time of this on site program review. The aforementioned sharps were inventoried weekly for the past six (6) months from August 10, 2014 through February 16, 2015. All counts are documented as counted and signed by the agency's Regional Coordinator.

The agency uses a Medication Record Log (MRL) to document all medication distribution activity for each resident that is admitted to the shelter with prescribed medication. The agency maintains a color-coded dot system to ensure the accuracy of each medication that is distributed to the resident. All residents with at least one or multiple MRL charts have a corresponding colored red, blue, green or yellow dot that corresponds with the appropriate controlled/narcotic or non-controlled medication.

At the time of the review, there was 1 CINS/FINS youth in the shelter on medication. This active youth's file as well as five (5) additional closed files was reviewed to verify the agency's adherence to the medication distribution process. Of the cases reviewed onsite, all cases had evidence that the medication entering the facility included documentation of verification and the staff person that completed the verification. The youth's Medication Record Log is maintained in the youth's individual file. All 6 MRLs reviewed documented the youth's name, a picture of the youth, allergies, side effects, 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. All MRLs reviewed on site document that perpetual inventory counts with running balances are being maintained on each resident. Further, shift-to-shift inventory counts for controlled medications and weekly inventories for non-controlled medications are being completed as required.

The agency has detailed disposal policy that requires any medication left over by a resident to be disposed of by the agency. The agency has instruction based policy that outlines the steps to be taken to properly dispose of any medication left at the shelter past 30 days. Both sharps such as EpiPens and or left over medication are to be placed in specific bio hazard waste disposal bags and transported to the CDS Bivens Oaks office where it will be disposed of by the agency's contracted waste disposal contractor Stericycle Medial Waste Systems.

The agency's Low Medication Supply practice requires that staff contact the parent/guardian of residents with a remaining 5-Day of their

prescribed medication(s).

There was one (1) medication error documented in July 2014. There error involved a resident receiving one pill of their prescribed medication and should have received two (2) pills of their prescribed medication.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The medical/mental health alert process has been instituted by the agency. There is a distinct label placed on the outside of each client file if there is a health alert pertaining to the health when intake was conducted. The allergy information is noted on page 4 of intake form. Although client may not have any medications, alert is still placed on file noting possible condition (due to past history) that can occur though there are no medications or active condition.

In addition, food allergies are noted on board in kitchen. In addition, a Medication board is posted in a visible area in youth care worker office for staff.

Three (3) of the six (6) files did have medication logs, so precautions were listed. However, there were 2 files that had alerts on them (not containing prescribed medication) that listed condition of client, but no precautions that should be noticed for the condition. Of the two files that are indicated by alerts, to find the concern pertaining to the alert, one must navigate through many pages and sections of the client file to look for history.

No exceptions noted.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency does have written procedures that ensure the provision of emergency medical and dental care. Full descriptions of emergency procedures including 911 procedures, skin wounds, fractures and sprains, dental trauma, nose bleeds, poisons, convulsions and seizures, head injuries, stings and bites, burns and scalds, and electrical burns are provided. See 1.03 for incident reporting for emergency care.

Fully stocked first aid kits are strategically placed throughout the facility. There is one located in the kitchen drawer, one located in the youth care worker's office wall, and one in the van. The knife-for-life and wire cutters are placed in a drawer in a locked youth care worker office.

No exceptions were noted for this indicator.