



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CHS Treasure Coast, WaveCREST

on 11/07/2012

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 Interagency Agreements and Outreach	Satisfactory
1.06 Disaster Planning	Satisfactory
1.07 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 Youth Room Assignment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Shelter Environment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Daily Programming	Satisfactory
3.06 Behavior Management Strategies	Satisfactory
3.07 Behavior Interventions	Satisfactory
3.08 Staffing and Youth Supervision	Limited
3.09 Staff Secure Shelter	Satisfactory

Percent of indicators rated Satisfactory:88.89%
Percent of indicators rated Limited:11.11%
Percent of indicators rated Failed:0.00%

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Psychosocial 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	No rating

Percent of indicators rated Satisfactory:80.00%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

Overall Rating Summary

Percent of indicators rated Satisfactory:92.86%
Percent of indicators rated Limited:3.57%
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

Marcia Tavares, Lead Reviewer-Forefront LLC; Larry Barnhill, Clinical Services Manager, Lutheran Services Florida Southwest; Paula Friedrich, OMC II, DJJ Prevention Services; Leonie Wellington, Quality Improvement Manager, Miami Bridge Youth and Family Services.

Persons Interviewed

- | | | |
|---|--------------------------|-------------------------|
| <input type="checkbox"/> Program Director | 0 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 1 Clinical Staff | 1 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 0 Food Service Personnel | 2 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 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 type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 0 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 0 MH/SA Records |
| <input checked="" type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 8 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 6 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 6 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input checked="" type="checkbox"/> Sick Call Logs | 6 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input checked="" 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

- 3 Youth 3 Direct Care Staff 0 Other

Observations During Review

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

Children's Home Society of Florida is one of Florida's oldest non-profit provider of services to children and families. The agency embarked on its 110th year of service this year and currently provides a variety of services for families in crisis, children at risk, and foster families, including children in the protectives services system and in residential care. The Treasure Coast Division, WaveCREST (Counseling Residential and Evaluation Services for Teens), was established in 1991 and currently operates the CINS/FINS program in St Lucie, Martin, Indian River, and Okeechobee Counties. CHS of Florida has been continuously accredited by the Council on Accreditation (COA) since 1982 and has received full re-accreditation, demonstrating CHS' commitment to maintaining the highest level of standards and quality improvement. The agency's re-accreditation with COA remains active through 2013.

The WaveCREST program is also committed to providing the most effective services to youth and families it serves. Since the last DJJ QI review, the program has added four Probation Respite beds to its residential program and has secured funding from the Department of Health and Human Services, Administration for Children and Families, for Basic Center services to runaway and homeless youth.

Standard 1: Management Accountability

Overview

Narrative

WaveCREST provides shelter and non-residential services for youth and their families in Martin, St. Lucie, Okeechobee, and Indian River Counties. The program, which is located at 4520 Selvitz Road in Ft. Pierce, Florida, is under the leadership of a Program Director. There are separate program supervisors in place for the shelter and non-residential components of the program. Shelter staff includes: a secretary, a residential supervisor, a group living manager and youth care workers. In addition to a supervisor, the non-residential component has three CINS/FINS counselors and two non-CINS truancy Counselors. At the time of the quality improvement review, the shelter had three (3) vacant Youth Care positions for two (2) relief and one (1) part time staff. The Department of Children and Families licensed WaveCREST as an emergency runaway shelter, with the current license in effect until February 28, 2013.

The program provides orientation training to all personnel through the agency's Learning Management System (LMS). Each employee has a separate training file containing a training plan and corroborating documentation for training received. Annual training is tracked according to the employee's date of hire. The program provides training through a combination of web-based and instructor-led courses.

Children's Home Society is the only facility serving runaway and homeless youth in its circuit. CHS has two designated Outreach staff who conduct outreach to inform youth of the dangers of living on the streets and services available in the shelter and non-residential programs. Staff conduct presentations to middle and high schools as well as community agencies in the circuit. There are currently over 100 Safe Place Sites located in the four counties served by CHS WaveCREST.

The Florida Network received the program's emergency response and hurricane plan that was revised on March 16, 2012. A Universal Agreement for Emergency Disaster Shelter is also in force and was signed by the Executive Director on February 24, 2012. The residential supervisor and group living manager ensure safety checks are conducted and staff duties are fulfilled.

1.01 Background Screening

Satisfactory Limited Failed

Rating Narrative

The agency has a policy and procedures in place that address the background screening of all employees and volunteers. The policy requires all staff and volunteers to complete a Level 2 Screening that includes good moral character documentation, background history checks, criminal record checks, and juvenile record checks. Additionally, the provider conducts a background check with the Division of Motor Vehicles prior to hiring.

A total of eight applicable personnel files were reviewed for six staff and two volunteers. Three of the staff were hired after the last onsite QI visit and all three received eligible screening results that were conducted by the Department of Juvenile Justice (DJJ) Background Screening Unit prior to hire. The remaining three staff files reviewed were eligible for 5-year rescreenings. Two of the three 5-year re-screenings were conducted within the required timeframe.

The program had three volunteers during the review period. All of the volunteers received eligible screening results from DJJ prior to their start dates. One of the three volunteers was hired by the program within a couple months of providing volunteer services.

In addition to the DJJ Background Screening, the provider also conducts annual driver's license checks through Lexis Nexis, and local county background screenings along with DCF background checks every five years from the employee's date of hire.

The Annual Affidavit of Compliance with Good Moral Character Standards was completed and submitted to the DJJ Background Screening Unit on January 12, 2012, prior to the January 31st deadline and recently again on November 1, 2012.

One of the three employee's eligible for the 5-year rescreening was not rescreened until four months past the 5-year anniversary date.

1.02 Provision of an Abuse Free Environment

Satisfactory Limited Failed

Rating Narrative

The program has a current policy and procedure in place for the provision of an abuse free environment. The Florida Abuse Registry Hotline number, rights and responsibility, and other relevant numbers posted at various locations throughout the facility such as the youth's bedrooms, hallways, and staff offices. Youth are also informed of these procedures during program orientation as well as in the Resident Handbook. The program also has a grievance box and forms accessible to youth in the dining room so that youth grievances can be accepted and resolved by staff. Upon hire, employees receive and sign receipt of the Agency's Code of Conduct which outlines the agency's expectation regarding the provision of a safe environment. Employees are required to report all known or suspected cases of abuse and/or neglect and youth have

unimpeded access to self-report.

There has not been any imposed discipline towards staff for any incidents related to abuse. Similarly, no incidence of youth being deprived of basic needs or abused by program staffs was reported during youth surveys conducted during the review or observed during the visit.

Abuse reporting was evident as staff called in an abuse for one of the active youth in the shelter who informed staff of the domestic abuse during the assessment session. The abuse was called in immediately by the staff and was documented in the case management notes. The abuse report was also documented in the providers AirsWeb incident reporting database.

All of the staff training files that were reviewed documented staff training in Child Abuse Reporting. The three youth surveyed indicated that they feel safe in the program and have never heard staff threaten them or other youth. None of the youth surveyed reported being stopped from reporting abuse. The three staff surveyed said they have never witnessed another staff prohibit youth from calling the abuse hotline and have never heard the use of profanity in the presence of youth or have observed staff use threat or intimidation when interacting with youth. All staff agreed the working conditions have been fair and/or good at the program.

No exceptions noted.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

There is a written agency policy and procedure pertaining to Incident Reporting currently in effect which complies with the indicator requirements of the program for notifying the DJJ Central Communication Center (CCC) of reportable incidents within two hours of the incident, or within 2 hours of becoming aware of the incident.

The program maintains their log of incident reports via a paperless computer system log. The program had 39 incidents included on their system log during the review period and seven of them were reportable incidents which were accepted by CCC. All 7 incidents called into the CCC within the review period were noted on the agency's incident report log and had been entered into the CHS incident accident database per the agency policy and procedure.

The 7 incidents reviewed within the review period were reportable per the DJJ Policy 8000 and were called into the CCC and accepted. All 7 incidents were called in within two hours of the incident/gaining knowledge of the incident as required. A review of the remaining 32 incidents on the database log indicated that none of the other incidents were reportable to the CCC due to either not being a reportable incident type, the CCC not accepting the report, or the incident not involving a DJJ youth (foster care youth).

The incident details were very legible as they are printed out from the database system, thereby eliminating problems with legibility. The database system is the sole means of recoding incidents and no handwritten logs are maintained any longer. The database printout of all incident reports does not include the name of youth. Incident types are described in the report only by use of a numerical code for each type, thereby making it necessary for the program to print the individual incident detail reports from the system for review during this QI visit. The program may consider revising the database report to indicate the type of incident in words rather than coded type, also consider adding to the report an indication of type of youth (CINS, Foster Care, etc) involved in each incident, and whether the incident was not reportable, reported to the CCC and accepted, or reported to the CCC and not accepted.

Interviews with three staff members indicate that the staff are familiar with the reporting procedures and requirements.

There were no exceptions to this standard found.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

There is an agency policy and procedure pertaining to Training Requirements. The agency policy and procedure complies with the minimum 80 hours of training during their first year of employment and 40 hours of job related training annually each full year thereafter.

The policy and procedure exceeds the indicator by requiring specific topics for annual training including fire safety, alarm system, crisis intervention, substance abuse interventions needed, and suicide prevention.

Two of six training files reviewed were for staff in their first year of employment. Both staff have exceeded the mandatory 80 hours of training within seven and five months of employment, respectively, which is well within the required one year time frame. All required training topics have already been completed or (in one instance) are already scheduled for completion prior to the one year anniversary date.

Four of six training files reviewed were those of staff employed for more than one year. Three of the four training files documented training

hours in excess of the 40 hours required by the indicator and the agency's policy & procedures. The 4th file documented 35 hours of training completed with 5 more hours to be completed by the end of this year. One training file indicated that one staff member had not yet completed suicide prevention training for this year but that training is already scheduled to take place on 12/12/12. The program has already scheduled training for the remainder of the calendar year to include gang & substance abuse (11/9/12) CPR/First Aid (11/24/12) suicide prevention (12/12/12) and ethical decision making (12/31/12).

There were no exceptions to this standard found.

1.05 Interagency Agreements and Outreach

Satisfactory

Limited

Failed

Rating Narrative

The provider's SOP CHS/7105 outlines procedures and activities the agency implements to build strong community partnerships and collaborations to ensure the provision of appropriate resources and supports for its consumers. The program increases community awareness on an ongoing basis and has an Outreach Targeting Plan to provide outreach services such as presentations, fairs, dissemination of printed materials to targeted neighborhoods and schools, community agencies, law enforcement, and local businesses. Informational and educational services related to alcohol and substance abuse, adolescent behavior, parenting, youth educational issues, and CINS/FINS program services are also provided to community youth and families.

The program maintains forty interagency agreements, including schools, health departments, law enforcement, and mental health, education, and recreation providers. All of the agreements reviewed have current contract/agreement dates and were signed within the last year.

Outreach activities are documented on a monthly basis and maintained in a binder. The outreach event form captures information about each activity such as: name, location, and date of the event; staff conducting the activity; target audience; age group of the target audience; target ethnicity; event purpose; method of service; and presentation summary. For the review period, May through November 2012, the program has provided outreach services to over 24,000 youth and adults (12,428 youth and 12,428 adults) in its service areas.

There are two designated outreach program staff whose duties include community outreach and the National Safe Place Program. Through Project Safe Place, the outreach staff manage multiple Safe Place sites, located in the four counties, and provide training, personnel, handouts, and support for all sites.

No exceptions noted.

1.06 Disaster Planning

Satisfactory

Limited

Failed

Rating Narrative

The program has a current policy and procedure (CHS/7106) that provides specific procedures for the implementation of its comprehensive safety and emergency preparedness plan. These general procedures include a description of the program's responsibility for: fire prevention, emergency disaster preparedness, conducting fire and simulated emergency drills, communication of emergency situations to staff, training, and execution of the Universal Agreement Emergency Disaster Shelter document.

The program also has a comprehensive Treasure Coast Division Emergency Response Plan (DERP) that was revised March 16, 2012 and approved by the local Fire Department on July 23, 2012. The Emergency Response Plan includes: 1) procedures for all of the required types of emergency situations with the exception of shooting emergencies; 2) evacuation sites for the shelter; 3) two meeting sites on the outside of the building in the event of evacuation; 4) evacuation routes to ensure safe and secure transportation; 5) checklist of all appropriate and necessary equipment; 6) staff contact list; and 7) notification procedures to the Florida Network and other funding agencies. The program participates in the Universal Agreement for Emergency Disaster Shelter with the Florida Network Member Agencies and the agreement was signed by the Executive Director on February 24, 2012.

Emergency response training is a mandatory annual training for all staff and is included in the provider's Learning Management System (LMS) and completed online by staff.

The agency's DERP lists Workplace Shooting under the procedures for Taking of Hostages; however, the procedures included on page MME-13 of the plan are more relevant for hostage take down situations and not shooting.

Also, the Executive Director's previous surname was changed earlier this year but was not updated in the DERP that was revised in March 2012.

1.07 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedures for analyzing and reporting data for case record reviews, incidents, accidents, grievances, customer satisfaction, outcome data, and monthly review of Netmis data reports. In addition, there is a comprehensive CHS Quality Management Plan, FY 2011-2012, that is comprised of three sections. Section 1 describes the agency's philosophy, Quality Management structure, CQI strategies, and stakeholders. Section II includes a description of the agency's long-term strategic goals and objectives, management/operational performance, and program results/outcomes. Section III provides procedures for data collection, aggregation of review and analysis, communicating results, using data for implementing improvement, and assessment of the effectiveness of the QM process.

The program has a designated Quality Management Specialist (QMS) who is responsible for the implementation and oversight of its CQI program. In practice, the program's CQI program includes many activities that are conducted by various staff to ensure all aspects of analyzing and reporting data are consistently implemented and documented.

Quarterly case record reviews are conducted by the program clinical staff as directed by the program supervisor and are due on the last day of the 3rd month of each quarter. Upon completion of each record review, the QMS aggregates the results and provide a copy of the aggregated report and Quality Management Division Evaluation to the program supervisor to discuss themes, trends, and any areas of concern. Program supervisors ensure appropriated follow-up is taken by their staff and responded to in a timely manner. The QMS also follow-up at a later date to spot check specific files to verify completion of the corrective actions.

The program's Safety Committee is responsible for reviewing incidents and accidents, performing safety checks and fire drills, and making recommendations to management on a monthly basis. Each program site has a representative who sits on the Safety Committee. The safety committee meets on the first Monday of each month and if unable to attend, can appear by phone. Minutes from each meeting are produced and provided to committee members (including the QMS) and the Executive Director (ED). The Division Safety Committee Coordinator discusses safety concerns and suggestions with the ED monthly and follows up with the QMS as needed. The QMS will follow up with the ED and program supervisors as needed to ensure division safety. Consumer grievances are submitted by program supervisors and reported to the QMS on a monthly basis via the PPR.

Consumer surveys are administered twice a year during the second and fourth quarters. The QMS addresses consumer surveying via email and at a management team meeting and notifies the program supervisors of the outcome of the surveys. The surveys are aggregated by the QMS and provided to supervisors, DPO, and ED. A copy of the Consumer Satisfaction Survey Tool for FY 2011-2012 was reviewed onsite.

Outcomes data is reviewed monthly, quarterly, and annually. Monthly and quarterly data is entered into the agency's Division Quality Performance Report (DQPR) into the following areas: program performance, program team minutes, safety, record review, consumer satisfaction, and outcomes. The outcomes data incorporates all of the contract, netmis, and program outcomes required by the Florida Network and DJJ QI. A copy of the year-to-date Annual Program Performance Report - Florida Network Outcomes, for FY 2012-2013 was reviewed on site.

No exceptions noted.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

WaveCREST is contracted to provide both shelter and non-residential services for youth and their families in Martin, Okeechobee, Indian River, and St. Lucie Counties. The program provides centralized intake and screening twenty-four hours per day, seven days per week, every day of the year. Trained staff are available to determine the needs of the family and youth. Residential services, including individual, family, and group services, are provided. Case management and substance abuse prevention education are also offered. Referral and aftercare services begin when the youth are admitted for services. Aftercare planning includes referring youth to community resources, on-going counseling, and educational assistance. The shelter staff includes a program supervisor, a secretary, a residential supervisor, a group living manager and youth care workers. The youth care workers are responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision.

The program has a very strong, efficient, well run centralized intake process in place. All staff are well trained on the process, display a knowledge of motivational interviewing, crisis counseling and gathering all pertinent information in a very professional was.

The non-residential component consists of a total of five (5) counselors, three (3) who are funded by CINS/FINS, and a program supervisor. The counselors are responsible for providing case management services and linking youth and families to community services. At the time of the quality assurance review, the non-residential component had forty (40) open cases.

CHS WaveCREST coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan 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.

2.01 Screening and Intake

Satisfactory Limited Failed

Rating Narrative

The program has a policy in place that outlines the screening eligibility for services and intake assessment process. The procedures set forth availability of access to services, the time frame for initiating a screening when a referral is received, who completes the screening, the different approved assessment tools, the criteria for eligibility for CINS/FINS services, and the process for referring families that are not eligible for services.

The program provides referral services 24 hours per day, 7 days per week and 365 days per year. The direct care, clinical staff, outreach staff and management staff are all fully trained on the completion of the referral form and the process. Referrals are reviewed daily by either the Shelter Supervisor, Non-residential Manager, or Residential Manager. The staff completes a full referral on everyone who calls in for services (parent, youth, law enforcement, school social worker etc.) When referrals were completed and the youth/family was deemed not eligible for services there was an appropriate referral to service made. During the evening, weekend, and holiday periods, there is always a Counselor on call to assist as needed with any difficulties arising from a request for services. Six (6) client files were reviewed: three (3) open non-residential files and three (3) closed residential files. All six files had screenings completed fully with all pertinent information provided and completed within seven (7) days of the referral. On one youth, the screening determined that an emergency did not exist and the youth was placed on a priority list. In each case the family was assigned to a counselor/case manager. In each case the youth and parent/guardian received in writing available service options, rights and responsibilities of youth, parent/guardians and a Consumer Handbook. After the completion of the intake assessment process the following assessment tools were completed on each youth: NETMIS, Consent for Services, CINS/FINS Intake Form, Risk Factor Form, Suicide Risk Screening and Brief FAM III.

No exceptions noted.

2.02 Psychosocial Assessment

Satisfactory Limited Failed

Rating Narrative

The program has a policy on Psychosocial Assessments in place. The policy includes but is not limited to time frames on the completion of a Psychosocial Assessment on both residential and non-residential clients. The procedures for the program designate who will complete Psychosocial Assessments, who reviews the completed assessment, the procedures for youth having suicide risk factors during the assessment, the information to be included in the assessment, and the approved assessment tools.

Six (6) client files were reviewed, three (3) non-residential files and three (3) residential files. Each case had a counselor/case manager assigned immediately upon the opening of the case. The three (3) non-residential cases had psychosocial assessments which were initiated and completed during the first face to face session with the family. The three (3) residential cases had initiated and completed psychosocial

assessments within seventy-two (72) hours of admission. Of the six (6) files reviewed, suicide risk assessments were completed on all six; only one (1) of the cases (residential) had an elevated risk for suicide. During the psychosocial assessment, the youth was referred and assessed by a Licensed Mental Health Clinician (LMHC), precautionary observation was discontinued, and the youth was placed on standard supervision by the LMHC. All assessments were reviewed and signed by a supervisor upon completion. All psychosocial assessments were completed by a Bachelor or Master level Counselor. All six (6) cases contained demographic information, dates of assessment, who was present for the assessment, reason for the referral/presenting problems, input from the youth and family on what s/he wanted to change, psychiatric/counseling history, mental, physical, emotional status, education history, family history and involvement, youth residential history, development history, medical history, legal history (DJJ/DCF), financial/employment history, drug and alcohol history, peer relationships, potential for violence/abuse, history of violence/abuse, strengths and weaknesses, and interests. Staff completed a summary with their impressions and comments. The Brief FAMIII, EIDS, and risk factors were completed in all cases.

No exceptions noted.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy on Service/Case Plans - Implementation, Review and Revision. The policy addresses who will complete the Service/Case Plan, who is involved in the planning, the time frames for the completion of the plan, the time frames for the review of each plan, what is to be included in the plan, and who is required to sign the plan.

Six (6) case files were reviewed, three (3) non-residential case file and three (3) residential case plans. In each case the counselor/case manager completed the service/case plan immediately after the completion of the psychosocial assessment. All service/case plans addressed the specific needs identified from the initial screening, intake and assessment. All six (6) service plans identified the needs of the youth and the family, each developed plan contained goals with measurable objectives. The types of services and/or treatment were clearly spelled out in each plan as well as the frequency of service or treatment and the location of service provision. All six (6) plans designate the responsible/accountable service provider or staff. Realistic time frames/target dates for completion were established with actual completion dates were noted appropriately. Each plan contained the date the plan was initiated. Signatures of the youth, parent/guardian, counselor and supervisor were found with the exception of one file where the youth was not available for signature. This was documented on the service plan and in the youth's progress note. The one file where the plan was not completed but initiated with the parent due to the unavailability of the youth was noted on the Children's Home Society Services/QA Checklist in the clients file. Each case file indicated that the counselor/case manager consistently and on a regular basis reviewed the youths/family's progress towards achieving goals on the plan and in three of the plans the goals were updated as needed with the youth and family's input. Documented goal achievement was noted the case file's progress notes appropriately and were updated as needed. Each file had the appropriate formal review of the service plans at thirty (30), sixty (60), ninety (90) days and every six months thereafter when it was due.

No exceptions noted.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy on Case Management and Services Delivery/Family involvement. The policy clearly details the roles of the counselor/case manager, the youth, the parent/guardian and the program.

Six client files were reviewed, three (3) non residential case files and three (3) residential case files. In all six cases there was a counselor/case manager assigned who followed the youth's case and ensured delivery of services through direct provision and in two (2) cases where referrals were made. In all six (6) cases, the youth and parent/guardian were engaged in all case planning service activities through the diligence of the counselor. All six (6) service plans were signed by the youth and family. Family sessions/conferences were scheduled routinely to access the family system's operations and difficulties, and documented in the case file progress notes. On three occasions these sessions were held via telephone due to the parents' inability at the time to have a face-to-face session. In all of the residential cases, the youth were either re-united with the family or prepared to do so. All contact with the family was documented in the case file progress notes. In two cases, referrals were made during on-going services and counseling to address a clinical need and the other a need for substance abuse treatment. Through the services provided by the program, none of the youth needed out of home placement. A referral was made to the CINS/FINS Case staffing Committee, in two of the cases, to address the problems and needs of the family. In each case, the child was adjudicated a "Child In Need of Services" (CINS). The assigned counselor/case manager accompanied the youth and parent/guardian to all court hearing and related appointments. Each case the counselor/case manager continued case monitoring and review of court orders.

No exceptions noted.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy for Counseling Services. The policy outlines and addresses the different types of counseling to be provided in both the non-residential and residential programs, based on the needs of the youth and family, as identified during the intake process.

Six (6) files were reviewed: three (3) non-residential case files and three (3) residential case files. In all six (6) case files reviewed counseling services were provided in accordance with the service plan. In the three (3) residential cases, group counseling was provided five (5) days per week. In all six (6) case files, the youth's presenting problems were addressed in the psychosocial assessment, initial case/service plan, case/service plan reviews, case notes maintained for all counseling services as well as in the case file progress notes. The files contained case notes for all counseling services provided with documentation of the youth participation and progress. In all cases, clinical reviews by the non-residential manager and residential manager were done on a regular basis and documented in the client files. Staff supervision was done on a monthly basis with the non-residential cases and weekly with the residential cases. In one of the non-residential cases, a referral was made and the youth was receiving clinical counseling from an outside provider. Also, a referral was made for another youth for substance abuse treatment who was also receiving services from an outside provider. Where appropriate, crisis counseling was provided by the clinical staff. All youth were identified with at least three (3) risk factors of the following domains: family, school, peers and individual anti-social behavior as identified on the DJJ Risk Factor questionnaire. The non-residential case files had clear documentation of the counselors' efforts to maintain a presence in, and target low performing schools as well as the high crime zip codes identified by DJJ. One of the non-residential youth and family needed respite due to family conflict; a referral was made to the shelter for the safety and protection of the child and/or family. The program maintains individual case files on all clients and adheres to all laws regarding confidentiality. The case notes in each file are kept chronologically on the youth progress. It was evident through the case file documentation in the progress notes that a wide array of counseling/case management services were offered and provided.

No exception noted.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy on Adjudication/CINS Petition Process - Case Staffing Committee. The policy outlines when it is appropriate to refer families to the Case Staffing Committee, the judicial process and requirements, time frames for referrals, who the case staffing committee includes as required by Florida State Statute 984, and other representatives from the community as deemed necessary.

Six (6) client case files were reviewed for five (5) non-residential case files and one (1) residential case file. Of the six (6) cases, two (2) of the non-residential cases and one (1) residential case was referred to the CINS Case Staffing Committee. The staffing was not requested by the parent in any of the case files reviewed. All three (3) cases were referred due to the youths' refusal to participate in services and refusal to participate or agree on a service or treatment plan. At the staffings, representatives were in attendance from the local school districts, the Department of Juvenile Justice, the youth, parent/guardian and the CINS/FINS Provider. Invited to the staffings were representatives from the local health care providers, mental health providers, substance abuse providers, the State Attorney's Offices, the alternative sanctions coordinator and law enforcement. Case Staffing Committees are established and conducted in all four (4) of the counties served by the program. In each case a service/treatment plan was created and presented to the families. A written report was provided to the parent immediately following the staffing outlining the reasons for the committee's recommendations and the reasons. In all three cases (3), the youth were adjudicated a "Child In Need of Services" (CINS/FINS). In each case, judicial intervention was provided for the family as recommended by the case staffing committee and the one (1) residential youth was being re-united with the family the day of the QI monitoring. The case manager coordinated court work with the DJJ General Counsel, including case management and completion of required court paperwork. The petition and predisposition reports were completed by the case manager and filed with the Clerk of Courts by the DJJ General Counsel. During the arraignment, the family was given the opportunity to admit or deny or consent to the allegations. In each case the child and the parent consented. Review summaries were held on each case and a review summary was prepared by the case manager. At the hearing, the court was informed of the child's behavior and compliance with the court orders as well as recommendations for further disposition.

There are case staffing committees in all four of the counties served by CHS and a representative from CHS attends each staffing held. In each of the cases reviewed, the family, school district representative and other committee members were notified at least seven (7) working days prior to the staffing. In each case, the youth/family was provided a new or revised plan for services. A written report was provided to the parent and school district representative, immediately after the staffing, outlining recommendations and reasons behind the recommendation. The CHS counselor in each case worked with the circuit court for judicial intervention for the youth/family. Prior to the hearing, in each case reviewed, a review summary with recommendations was completed.

No exceptions noted

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy on youth records and case management services. The policy outlines when files will be opened, how they are maintained, where they are maintained, and for how long they are maintained.

Six (6) files were reviewed: three (3) non-residential files and three (3) residential files. All of the files were stamped confidential and kept in a locked file cabinet which is also marked confidential and is located in the direct care office which has two (2) locked doors. All staff have access to the files. A Confidential file was created and maintained for each of the youth upon admission to the program. All of the case files reviewed were systematically organized as evidenced by the file checklist in each file. All of the files were neat, well kept, and were numbered according to the residential or non-residential programs. All case files documented the case management, counseling and documentation of client progress. Two (2) of the case files reviewed contained documentation on appropriate referrals made for the individual youth, one (1) for substance abuse and the other for clinical services. All client files contained an assessment of needs and service plan implementation.

No exceptions noted.

Standard 3: Shelter Care

Overview

Rating Narrative

WaveCREST Shelter is located in central St. Lucie County. The facility is licensed by the Department of Children and families for 12 beds; the Department of Juvenile Justice (DJJ) contracts for six CINS/FINS beds. The shelter also admits youth from the Department of Children and Families (DCF) and also for the Basic Center and Street Outreach Programs. At the time of the quality assurance review, the shelter was providing services to eight CINS/FINS youth. The shelter is not designated by the Florida Network to provide staff secure services and is not licensed under Chapter 397.

The building occupied by the shelter program is over forty years old, and is leased by Children's Home Society from St. Lucie County. During the tour, the facility was found to be in good working condition and the furnishings in good repair. The bedrooms, kitchen, restrooms and common areas were clean. Each sleeping room is numbered and the beds are identified with letters. Four of the bedrooms house two youth, each with an individual bed, bed coverings and pillows. The other two bedrooms are equipped each with a bunk bed and a twin bed which gives the program the flexibility to accommodate more youth of one gender when necessary. Youth have access to a screened porch with free weights, a piano, pool table, and a large backyard with a basketball court.

3.01 Youth Room Assignment

Satisfactory Limited Failed

Rating Narrative

The program has a policy in place that complies with Quality Improvement standard 3.01: Youth Room Assignment. The program's procedures outline steps taken to ensure the safety and security of all residents in care.

During the review, three (3) resident files were reviewed. As indicated in the individual files on the *CINS/FINS Intake Assessment* form, youth are interviewed at intake to determine appropriate sleeping arrangement and bed assignment. Classification of residents is documented on the program's Intake Form and alert form. These forms list specific alerts, identifying resident with special needs. In addition, the intake board record classification and room assignment of resident as well as list pertinent information that clearly identifies each resident residing in shelter.

No exception noted.

3.02 Program Orientation

Satisfactory Limited Failed

Rating Narrative

The program has a written policy that describes educational opportunities to resident which outlines the program's expectations. The three (3) resident files reviewed documented completion of orientation within 24 hours of the intake date and time. At the time of admission, resident and parent/guardians receive a residential handbook that explains the principal rights, rules, and responsibilities, behavior management process, grievance procedure, and program schedule and services. All of these items are documented on the *youth orientation checklist* and signed by resident and staff. The information is also posted on bulletin boards in various areas throughout the facility and is visible to resident and staff.

Four (4) employee training files reviewed revealed staff training in the program's orientation process.

No exception noted.

3.03 Shelter Environment

Satisfactory Limited Failed

Rating Narrative

The program provides a policy on the upkeep and maintenance of the facility. The program has a house keeping/maintenance binder that logs weekly inspections, needed repairs and maintenance. The binder also stores lawn service, waste management, and pest control invoices for work performed on the property.

During the tour, the facility was observed to be clean and in good order. Sleeping quarters, restroom and common areas were well-maintained and functional. There were no visible graffiti markings on the furniture, walls, or doors.

There are a total of six (6) dorm rooms, four house two (2) beds, and two (2) of the dorm rooms furnish a bunk bed besides an additional twin bed, allowing the program to accommodate more youth of a particular gender when needed. There are bed coverings and pillows on individual beds. Beds are labeled with letters for identification. The front living room area house a bed specifically for suicide watch and medication observation.

All inspections reviewed during the visit were found to be current. The St. Lucie County Fire Marshal's Office conducted a satisfactory annual fire inspection on 7/23/2012 and approved the provider's Emergency Response Plan on the same date. No safety violations were noted. Semi-annual Alarm testing and inspection as well as a semi-annual Range Hood inspection were conducted on 9/4/2012 and 6/4/2012, respectively. Quarterly fire equipment inspections were conducted by Fire Equipment Services on March 23rd, June 27th, and September 28th. Fire

extinguishers were serviced and tagged and are valid.

The most recent satisfactory annual residential group care combined with food service inspection was conducted on 11/23/11. One violation regarding the maintenance of plumbing in the boy's bathroom in compliance with the State plumbing code was cited and is to be corrected prior to the next inspection

No exception noted.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The program has a process for log book documentation to record daily activities, events, and incidents. The logbook documents important information such as: all information occurring during each shift including intakes, youth activities, youth counts, visitors, incidents/accidents, specific information about youth's behavior, staff signing in/out and review of the logbook, and alerts. Entries are written in black ink unless otherwise specified and include the date and time and are signed by the individual making the entry. Any major incident or anything that affects the safety and security of the facility is highlighted in the logbook. The date and day is written at the top of each page.

The log book is reviewed on each shift for the two (2) previous shifts and signed off and dated by staff. The program supervisor conducts weekly reviews of the log book and document notes of recommendation and corrections in the log book.

The program's procedure outline steps to correct errors made in the log book. However, the log book review revealed inconsistency with the error correction policy (CHS/7304, 2(b) and not all voids were corrected with a single line, drawn through the entry, the writer's signature, "Void" written by the error, and the date of the correction.

Rating Narrative

The program has a policy that provides structured daily activities to enhance resident in social skills and physical development. The program's activity schedule was reviewed for daily programming. It provides a variety of services with age appropriate activities. The program's activity schedule is posted monthly and is accessible to resident and staff.

A monthly calendar is maintained in addition to the daily program schedule that includes various recreational, faith-based, social, and educational activities. The schedule includes time for group sessions daily, recreation, and other activities. Participation in faith-based services is voluntary and youth can attend religious services with family members. Parents are required to provide permission in writing in order for their youth to attend religious services with others. A minimum of one hour per day is allotted for reading and/or study time to complete home work. The provider has a wide variety of agency approved, age appropriate books for reading. The bookshelves are located in the youth living area. Ample time is also allotted for recreational activities ranging from skating, movie night, game night, Wii Sports, and other outings. Groups are scheduled Monday-Friday between 5-6 p.m.

No exception noted.

3.06 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The program has a current policy that provides information on the program's behavior management system (BMS). Residents are provided information on the behavior management system during the resident orientation process as indicated by resident and staff on the program's orientation checklist. The behavior management system outlines minor, major, and maximum discipline behaviors of resident.

Inappropriate behaviors and relevant consequences are visibly posted in the living room of the shelter and in each bedroom. Staff who have been trained in the use of the BMS score youth's behavior daily before house meeting. The youth care staff reviews the point sheets with each youth daily. Points are earned based on rule compliance, attitude, peer/staff interaction, participation in activities, use of leisure time, and school behavior. The program uses a variety of rewards to encourage residents to comply with the program rules and expectation. It also provides positive reinforcement and feed back to resident concerning consequences and choices. Points earned can be used to purchase items from the point store. The program displays items in the point store allowing resident to make purchases using their points earned from the behavior management system.

Four (4) employee training files review direct care staff behavior management training which is offered during employee orientation process.

No exception noted.

3.07 Behavior Interventions

Satisfactory

Limited

Failed

Rating Narrative

The program provides a policy on behavioral intervention to address consequences and sanctions for the program rule violations that are serious to inappropriate behaviors exhibited.

Employees receive training in crisis intervention and de-escalation techniques to manage inappropriate behaviors. As indicated in the program's policy, physical intervention by employee is prohibited.

Three (3) youth files were reviewed to determine the program's use of behavioral interventions. The file review demonstrates that there are procedures in place for the implementation of techniques used to engage youth and that youth are consistently disciplined appropriately. The program does not use room restriction as an intervention and physical intervention is used only as a last resort. Rather, positive reinforcement for appropriate behavior, redirection, and verbal intervention are the primary behavioral management tools used. None of the CCC incidents reviewed onsite involved the use of physical intervention. Four (4) employee training files reviewed revealed current training in behavioral interventions.

No exceptions noted.

3.08 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy (CHS/7308) for staffing and youth supervision to ensure adequate staffing is provided that optimizes the safety and security of all youth and staff. The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. The shelter is licensed for 12 beds and the staff schedules reviewed for the review period reflect staffing ratios of 1 staff to 6 youth during awake hours and community activities and 1 staff to 12 youth during sleep period.

The staff schedule is provided to staff and is posted in a place visible to staff in the Intake Office. There is an overtime rotation roster which includes the home telephone numbers of staff who may be accessed when additional coverage is needed.

Staff observe youth at least every 10 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or when youth are in their sleeping rooms.

The program accepts both males and females; however, there isn't always at least one male staff on duty even when youth of the same gender is present. Additionally, the overnight shifts did not always provide a minimum of two staff present as required.

3.09 Staff Secure Shelter

Satisfactory

Limited

Failed

Rating Narrative

Not applicable - CHS WaveCREST is not designated by the Florida Network of Youth and Families as a Staff Secure Shelter.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

CHS WaveCREST has specific procedures related to the admission, interviewing and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. Upon admission, program staff will interview youth. 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. Staff conducting the initial interview and assessment considers the youth's physical characteristics, maturity level, history including gang or criminal involvement, potential for aggression, and apparent emotional or mental health issues. Based on this information, the youth is assigned a room which can change after further assessment. Room assignment is documented on the CINS/FINS Intake Assessment page 2. Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The residential manager and/or Youth Care Supervisor is notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented on the alert board, youth alert forms, and in the youth files using a color coding system. Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission. Medications are stored in a double locked red medication cabinet and topical and/or injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication ensures that an approved staff is scheduled on each shift. Medication records are maintained for each youth and stored in a MDR Binder.

4.01 Healthcare Admission Screening

Satisfactory
 Limited
 Failed

Rating Narrative

There is a written policy that adheres to the requirements indicator.

Three files were reviewed and all were found to include screening for current medications, existing medical conditions, allergies, recent illnesses and injuries, observation for evidence of illness, injury, pain or physical distress and difficulty moving as well as observation for presence of scars, tattoos, and other skin markings. The health screening queries were also complete in all 3 files for chronic medical conditions of diabetes, pregnancy, seizure disorders, cardiac disorders, asthma, tuberculosis, hemophilia and recent (previous two weeks) head injuries.

The program's policy and procedure includes a referral process and process for any necessary follow-up medical care for any admitted youth with chronic medical conditions including discussion of the medical needs with the parent/guardian, transportation, etc.

There were no exceptions to this indicator found.

4.02 Suicide Prevention

Satisfactory
 Limited
 Failed

Rating Narrative

There is a written policy and procedure for suicide prevention. The policy requires that each youth be screened for suicide risk in accordance with the policy and procedure manual.

Suicide risk screening is included as part of the initial intake and screening process using the CINS/FINS Intake Assessment Form and was completed in 3 of 3 files reviewed, and included the supervisor's signature and documentation in the client files.

In 3 of 3 files reviewed, the suicide risk screening was completed during the initial intake and screening process, results were signed by the supervisor and documented in the client file. In 3 of 3 files youth who scored on the EIDS were placed on sight and sound supervision until they were released by a licensed professional and placed on appropriate level of supervision based on the results of the suicide risk assessment until supervision level was changed by the licensed professional (2 of 3) or the youth was Baker Acted (1 of 3).

No exceptions to this indicator were found.

4.03 Medications

Satisfactory
 Limited
 Failed

Rating Narrative

There is a written policy and procedure in place which addresses the safe and secure storage, access, inventory disposal and administration/distribution of medications as required by the indicator. The procedures and practice observed provide for all medications to be stored in separate, locked cabinet that is inaccessible to youth.

There are currently 11 staff designated in writing who have access to secured medications. Perpetual inventory with running balances are maintained with each shift and practices were observed via review of youth files and were found to be consistently maintained without exception.

Over the counter medications are also maintained in a locked cabinet in a locked room. Oral medications are stored separately from topical and injectable medications. The only injectable medication maintained by the program is the EpiPen. Youth on regularly prescribed injectable medication (such as insulin) are precluded admission to the facility. The program maintains a secured refrigerator in a locked room that is used for medication storage only, but no refrigerated medications were on site on the date of this review.

Narcotics/controlled medications are stored in a locked box within a locked cabinet. Medication records were verified to contain the youth name, date of birth, allergy information, side effects/precautions, a picture of the youth, staff and youth initialed medication records. The full printed name, position title and signature of each staff member were present for each staff member who had initialed administration of each dosage. The youth signature and printed name were also included as well as their initials acknowledging receipt of each dosage. The time of administration of daily dosages was documented consistently within the Medication Log Record as required by the policy and procedures.

Client file review demonstrated that documentation is regularly maintained for attempts to obtain medical information from the parent/guardian.

Staff surveys demonstrated that those staff who assist with medication do know where to seek information on medication side effects and medical alerts. Staff rated the communication of alert information as "good" or "very good".

Client survey's demonstrated that 1 of the 3 youth surveys has sought medical care while in this facility and rated the care as very good.

No exceptions to this indicator were found.

4.04 Medical/Mental Health Alert Process

Satisfactory Limited Failed

Rating Narrative

The program has a medical and mental health alert system in place to ensure communication to staff all information concerning a youth's medical condition, allergies, possible side effects of medications, contraindicated foods/meds, and other pertinent health treatment information. A copy of the program's plan (Comprehensive Master Plan for Access to Mental Health and Substance Abuse Services) was provided to this reviewer.

Observation and file review indicates that the system in place includes alerts/precautions relating to prescribed medications, and medical/mental health conditions.

All staff are provided ongoing emergency care training including, first aid, CPR, training on recognition of possible signs of mental health/substance abuse issues. A review of training files indicates that all staff are current on their training plans.

Three files were reviewed for youth who presented a medical or mental health alert. One of the youth was assessed as being a suicide risk but the suicide alert was not indicated as a risk even though the youth was placed on precautionary observation and was removed by the licensed clinician. The provider's policy and procedures do not include the identification of suicide risk alerts for youth with a history of suicide risk on the red alert page within the youth's file or for those youth in the program with a current suicide concern.

4.05 Episodic/Emergency Care

Satisfactory Limited Failed

Rating Narrative

The program maintains a written policy and procedure for episodic and emergency medical and dental care. The policy includes procedures for obtaining off-site emergency services, requirements for parental notification and contact, and the maintenance of a daily log.

A review of 3 closed youth files and 1 open youth file documented the practice dictated by the policy and procedure. Two (2) of the four (4) files indicated that emergency medical care was required (one youth was Baker Acted and the other required emergency medical evaluation for what was determined to be a panic attack). Both files included detailed documentation that the required contact was made with the parent/guardian as well as detailed notation within the daily log.

Review of staff training files documented that staff have received and are current with training on safety and emergency medical procedures (CPR, First Aid [including dental trauma], suicide prevention, recognition of mental health and substance abuse issues, crisis intervention, etc.)

First aid kits are maintained in several locations within the facility. The suicide kit (Knife-for-life and wire cutters) is maintained attached to the wall just above the time clock next to the census board.

No exceptions to this indicator were found.