



# **Florida Network of Youth and Family Services Quality Improvement Program Report**

Review of Florida Keys

on 12/10/2014

## 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

Marcia Tavares, Lead Reviewer, Forefront LLC  
 Marie Boswell, Delinquency Prevention Specialist, Department of Juvenile Justice  
 Brian Dye, Residential Services Manager, Stewart Marchman Act  
 Mary Williams, Program Director, Center for Family and Child Enrichment

**Persons Interviewed**

- |  |                          |                         |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 1 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 | 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                         | 3 Health Records                                    |
| <input checked="" type="checkbox"/> Continuity of Operation Plan      | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 3 MH/SA Records                                     |
| <input type="checkbox"/> Contract Monitoring Reports                  | <input type="checkbox"/> PAR Reports                                 | 12 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 type="checkbox"/> Sick Call Logs                              | 3 Youth Records (Open)                              |
| <input type="checkbox"/> Exposure Control Plan                        | <input checked="" type="checkbox"/> Supplemental Contracts           | 1 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 checked="" type="checkbox"/> Posting of Abuse Hotline      | <input checked="" type="checkbox"/> Staff Supervision of Youth       |
| <input type="checkbox"/> Confinement                     | <input type="checkbox"/> Program Activities                       | <input type="checkbox"/> Tool Inventory and Storage                  |
| <input checked="" type="checkbox"/> Facility and Grounds | <input type="checkbox"/> Recreation                               | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage |
| <input checked="" type="checkbox"/> First Aid Kit(s)     | <input type="checkbox"/> Searches                                 | <input type="checkbox"/> 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 checked="" type="checkbox"/> Staff Interactions with Youth |  |

**Comments**

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

Rating Narrative

## Strengths and Innovative Approaches

### Rating Narrative

The Florida Keys Children's Shelter, Inc., is a non-profit community-based corporation sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary Children In Need of Services/Families In Need of Services (CINS/FINS) residential and non-residential services to youth and families in Monroe County. The agency provides a full range of services to both male and female youth under the age of 18 years. The program is located at the Tavernier's Jelsema Center, at the north-end of Monroe County next to the Tavernier Government Center.

In May of 2012, the Florida Keys Children's Shelter (FKCS) was re-accredited by the Council on Accreditation (COA) and has been continuously re-accredited by the Council on Accreditation (COA) since its accreditation in May 2004.

Since the last QI visit in January 2014, the provider has changed its agency management structure with the replacement of its former Chief Executive Officer (CEO) Mr. Brown with two co-CEOs Bill Mann and Benjamin Kemmer. Mr. Mann and Mr. Kemmer have both served in Management positions with the agency for over twenty years combined.

In addition to the replacement of the former CEO, the provider has experienced staff turnover since the last onsite QI visit and has eleven (11) new hires of which four (4) are Non-Residential Counseling positions. Fortunately, two of the four new community-based counselors are licensed professionals.

The provider continues to improve overall agency and program outcomes through advancing youth life skills and development, health and wellness, transitional housing, and fundraising. Through its education initiative, it seeks to develop relationships with Universities near and far to provide experiential learning opportunities for Interns and training/skill development opportunities for staff. The agency partners with the University of Miami and Universities across the country to collaborate on web-based training, conferences, and other activities focused on dealing with youth issues. The program utilizes interns to assist with counseling and case management and has mutually benefitted tremendously from this assistance. Funded by an Eckerd Grant, this education initiative will help in bridging the gap and establish relationships that will facilitate the recruitment and utilization of interns and potential staff. Another education initiative is the collaboration with FKCC to provide opportunities for youth to get into a community program.

Another successful Mayor's Ball fundraiser was conducted in January 2014. The agency had its highest attendance rate of 318 people at the Ball and raised \$25,000 from the event. The ball is known to attract many high ranking local officials and businessmen and is a great publicity event for the agency. During the onsite visit, the provider was planning its Mayor's Ball for the current year.

## Standard 1: Management Accountability

### Overview

#### Narrative

FKCS has been in operations since 1985. The agency has an eleven-member Board of Directors/Trustees, including a youth member, with representatives from the upper, middle, and the lower keys, to oversee the agency's goals, objectives and activities. The FKCS building houses the CINS/FINS shelter on the first floor and the agency's administrative offices on the second floor. The shelter provides separate female and male dormitories to children under 18 years of age that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at risk.

The program has a Senior Management team that is comprised of two Co-Chief Executive Officers, formerly the COO and the Chief Learning and Evaluation Officer (CLEO), a Chief Financial Officer (CFO), and Chief Development Officer (CDO). In addition, the program has a licensed Counseling Services Coordinator and a residential Program Coordinator. There were no staff vacancies at the time of the review.

At the time of the onsite visit, the shelter program staff included: a Program Coordinator, two Team Leaders, a Youth Advocate, nine Youth Support Staff, a Food Service Manager, and a Maintenance staff. In addition to the Counseling Services Coordinator, the clinical component has three community-based Counselor positions, assigned to the upper Keys, Marathon, and Key West, and one Residential Counselor.

The program has an Annual Training Plan for all staff and all employees receive ongoing training from the program's designated trainer, local providers, and the Florida Network. Orientation training is provided to all personnel by the CLEO. Each employee has a separate training file that contains a training plan and corroborating documentation for training received. Annual training is tracked according to the employee's date of hire.

FKCS maintains valuable interagency agreements with several agencies that ensure a continuum of services for the youth and families. The program has a strong outreach component, with participation of all program staff, with emphasis on areas designated as high crime zip codes. Community based staff provide services throughout the county and maintain offices in schools located in the upper, middle, and lower Keys.

### 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 provider's policy reviewed onsite requires all potential employees, volunteers who work alone with youth, and interns to successfully complete a background check prior to an offer of employment or provision of service within the program. The background screening includes Department of Juvenile Justice Criminal History Acknowledgement, Request for Live Scan, and Affidavit of Compliance with Good Moral Character forms. Additionally, the provider conducts quarterly local background checks for all employees, annual driver's license checks through Greg Roe Insurance Company, and drug screenings at hire and randomly thereafter. The program maintains personnel records of employee's background screenings in their personnel file.

A total of twelve (12) background screening files were reviewed for eleven (11) new hires and one (1) employee who was eligible for a 5-year background screening for the review period. All of the new hire personnel had timely background screenings completed prior to their hire dates.

The program provided a copy of its Annual Affidavit of Compliance with Level 2 Screening Standards and evidence that it was submitted to the BSU on January 14, 2014.

Exception:

The 5-year re-screening for one applicable employee, date of hire 6/22/09, was not completed by the five-year re-screening anniversary date; the re-screening was completed late on 7/14/14. The provider began doing E-verify in August 2014; consequently, only four (4) of the eleven (11) new hires had been E-verified.

### 1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a comprehensive policy regarding Child Abuse Reporting, policy #1.07.01-1.07.03, to ensure the provision of an abuse free

environment. The policy requires the prominent posting of the Abuse Registry phone number. Postings of the Abuse Hotline number are observed in the lobby, youth living room area, and in the client handbook. The program's policy specifically complies with DJJ policies related to incident reporting, and require program employees and volunteers to report all known or suspected cases of abuse and/or neglect to the Florida Abuse Hotline. Both paid staff and volunteers are expected to abide by the agency's rules of conduct that foster an abuse free environment and prohibit intimidation, physical abuse or force. All new staff members receive training regarding the requirement of reporting incidents of alleged child abuse as a part of their initial orientation training. A review of four calls made to the abuse registry demonstrated that staff is aware of the reporting requirement when youth alleges abuse.

The program also has a policy in place that requires families and youth to be informed of their right to grieve; youth acknowledge their understanding of the process by their signature at intake. The program maintains blank grievance forms at the entrance to the male and female dormitories. There were no receptacles available for depositing completed grievances; instead, the Shelter Manager stated that youth typically hand him their grievances or request to speak with him.

The program provided copies of 3 grievances filed in the facility during the review period. The grievances were resolved and acknowledged as such by the youth at the informal phase as outlined in the program's grievance policy. There were no personnel actions taken against staff as a result of grievances filed, abuse, intimidation, or excessive use of force.

Three youth were surveyed during the review and all three indicated that they know the Abuse Hotline was available to them and where the number was located in the facility. All three youth indicated that staff is respectful to them and no adult had ever used threats or profanity towards youth. However, one youth stated s/he does not feel safe at the shelter because it is not their home. The grievance process was known to all three youth surveyed. The facility was observed to be free of graffiti and all of the youth surveyed indicated that they feel safe at the facility.

Three staff members were also surveyed for this review. All three staff indicated that the working conditions were very good at the facility. All three described appropriate procedures to facilitate youth calls to the Abuse Hotline. None of the three staff surveyed have ever observed a co-worker telling a youth they could not call the Abuse Hotline. None of the three staff have observed a co-worker using profanity when speaking with a youth or using threats of intimidation, or humiliation when interacting with a youth.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

#### Rating Narrative

The program has established a written policy and procedure for Incident Reporting that requires compliance with the Florida Department of Juvenile Justice (DJJ) Central Communications Center (CCC) requirements. Specifically, the policy requires incidents to be reported to the CCC as soon as possible, and no later than two hours of the incident/gaining knowledge of the incident.

The program maintains documentation about incidents in a binder. During the reporting period, only one incident met the criteria for reporting to CCC. The incident involved the arrest and criminal charge against a staff member. Program staff called in the incident to CCC within 2 hours of becoming aware of the arrest. Follow-up documentation was reported to CCC as well as documented in the file. As a result of the arrest, the staff was terminated effective immediately.

Several other incidents classified as Unusual Events were documented, filed, and reviewed onsite. A review of these incidents, for the preceding six month time period, indicated that none of them were reportable to the CCC due to not meeting the criteria.

The reviewer noticed that a significant number of the Unusual Events pertained to youth escaping the shelter through the window. The provider is aware of these incidents and is attempting to obtain funding to add security alarms to the facility windows.

### 1.04 Training Requirements

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a comprehensive training policy and procedures to ensure the provision training in necessary and essential skills required for staff to perform specific job functions. Upon review of the policy and procedure, five of the mandatory training topics (Medication, Ethics, Professionalism, Trauma Informed Care, and PREA) for new staff were not included in the providers list of required training during the first year. However, during the onsite visit, the provider updated its policy to include these topics.

In addition to its policy and procedures, the provider has an annual Training Plan for FY 2014-2015 that describes its protocol for complying with the training requirements. A copy of the Training Plan was provided submitted to the Florida Network for approval on September 12, 2014.

Training is provided through various means including online using the Florida Network's Dizzy Baby, external professional trainers, supervisors, and the agency's former Chief Learning and Evaluation Officer (CLEO). The former CLEO develops a training plan with each staff annually and

monitors training on a regular basis to ensure staff receives the required training throughout the year. The program maintains an individual training file for each staff member that contains a log of training courses/hours completed and certificates. The program exceeds the requirements of the indicator and has an established protocol requiring staff to complete their required training during the first year of employment and thereafter.

The training files of three new hire employees and three in-service staff were reviewed. All of the new hires have exceeded the 80 hours of training required as of the date of the review. In addition, two of the three staff had completed all of the mandatory training topics. The third new hire was missing only one training topic but still has five months remaining to complete the training.

Two of the three in-service employee files reviewed exceeded the 40 hours required annually while the third staff had completed 40 hours required. All three employees completed the refresher CPR/First Aid and Fire Safety Training required for in-service staff annually. In addition, as of the date of the QI review, two of the three staff completed all of the recommended trainings.

Per the agency's CLEO, the program's Licensed Clinical Supervisor and those staff certified as competent are the only staff used to conduct an Assessment of Suicide Risk (ASR). Since Non-licensed staff does not complete the ASR, the training requirements associated with this indicator are not applicable for these non-licensed counselors. However, the provider's policy and procedure does not include this policy and must be updated to reflect the aforementioned policy. As of the date of this QI visit, the provider had a total of 4 Non-licensed Clinicians and one LMHC Supervisor. The Non-Licensed Clinician training for ASR was waived for one of the Clinicians who was hired prior to July 1, 2014. A written letter, dated 1/31/14, confirmed that the non-licensed clinician has received training and is competent to complete ASR. The letter was signed by the LMHC and included the LMHC's license number. In practice, the three mental health case files reviewed, in which an ASR was completed, were completed by the provider's Non-licensed Clinician who was certified as being competent.

Overall, the provider does an excellent job in ensuring staff receives the training required as well as those necessary to serve its at-risk youth population. Training records are well maintained and consistently documented with certifications, sign-in sheets, handouts, etc. The annual training plans developed between the staff and the program supervisor ensures accountability and delivery of appropriate training for each staff.

### 1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a written policy establishing collection of data from several sources to identify patterns and trends for case record reviews, incidents, accidents, grievances, customer satisfaction, outcome data, and monthly review of Netmis data reports.

The agency's Co-CEO, formerly CLEO, is responsible for the implementation and oversight of the program's PQI activities. In practice, the agency's PQI 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 with a random selection of 40% of the client and human resource records are conducted by the program's clinical staff as directed by the Co-CEO. The reviews are conducted the first week of each quarter beginning in January each year and documented on the Record Review Checklist. The provider submitted Case Record Reports for the 3<sup>rd</sup> and 4<sup>th</sup> quarters of FY 2014-2015 showing a total of 10 residential and 34 non-residential files reviewed for the periods. Upon completion of each record review, the Co-CEO aggregates the results and provides a copy of the aggregated report to the Executive Council, Leadership, and Direct Care Staff. Program Supervisors ensure appropriated follow-up is taken by their staff in a timely manner. Deficiencies are corrected within two weeks of the records review.

The Co-CEO conducts quarterly reviews of all issues regarding employee and client safety. The Safety Review consists of statistical information compiled from risk management, human resources, performance quality improvement, direct care and program staff. Management and direct care staff meet to discuss safety issues, licensing audits, and reports related to safety and risk management. The provider submitted Risk Prevention and Management Quarterly Reports for the 2<sup>nd</sup> and 3<sup>th</sup> quarters of 2014 showing a summary of the number and/or types of incidents, fire drills, staff or client grievances, and work related injuries as well as results of fire and health inspections.

Consumer surveys are administered for staff and stakeholders annually and quarterly for youth in the program. The annual employee satisfaction surveys and stakeholder survey data are aggregated by the Co-CEO and presented to the agency constituents. Report for FY 2013-2014 client satisfaction survey and 2014 Consumer Survey were reviewed on site.

Outcomes data is generated by the CEOs and included in the Providers Monthly Leadership Report. Data is collected on program effectiveness, client outcomes, and CQI. The outcomes data incorporates all of the contract, Netmis, and program benchmarks required by the Florida Network and DJJ.

The provider conducts Netmis data review monthly. The Netmis data is presented to the FKCS Leadership Meeting (Administrative and Program Staff) meeting by the CEOs. Copies of the meeting agendas, and handouts for meetings held during the past six months were reviewed during the visit.

## Standard 2: Intervention and Case Management

### Overview

#### Rating Narrative

FKCS is contracted to provide both shelter and non-residential services for youth and their families in Monroe County. The program provides centralized intake and screening twenty-four hours per day, seven days per week, every day of the year. Staff are trained staff to determine the conduct screening and immediately assess the needs of the family and youth. Residential counseling services are provided by only Master's level Counselors who conduct individual, family, and group services. Case management and substance abuse prevention education are also offered in both the residential and non-residential service programs.

The Community-based program offers both school and home based services that are divided between three (3) full time counselors under the supervision of the program's Counseling Services Coordinator who is a Licensed Mental Health Clinician (LMHC). The counselors are responsible for providing case management services and linking youth and families to community services. The community based services span the entire Monroe County. The program's non-residential counselors work out of local schools in the upper, middle, and lower Keys in Key West, and provide prevention services to youth in the county utilizing several schools as the base of operations in their respective communities. 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.

FKCS 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. There was evidence during the file review that the provider conducts case staffing when appropriate and follows the requirements of the indicator.

The review of the charts shows that required documentation is in place and all services are being provided to the youth and families in a timely manner by the counselors and case managers.

### 2.01 Screening and Intake

Satisfactory

Limited

Failed

#### Rating Narrative

The policy and procedure requires the youth to be assessed and screened to determine the eligibility for services in the FKCS. In the policy it states all initial screenings are to be completed using Netmis Youth Screening and CINS/FINS Intake form during initial contact or within 24 hours of admission. The policy and procedure also states the comprehensive assessment (Needs Assessment) is to be completed within 72 hours of admission.

As of the date of the QI Review, (6) files were reviewed for three (3) open non-residential youth and three (3) closed residential youth files. All (6) files reviewed today had an eligibility screening that was completed within 7 calendar days of the referral date. The files included a Parent Handbook notice, which included: Notice of privacy, Grievance policy & procedures, Consumer Rights & Responsibilities, and Residential Consumer's Day to Day Rights & Responsibilities. Also, included was a Resident Handbook Notice for residential cases. The notice form required the signatures of the client, parent, and assigned counselor/staff. Also, in the FKCS Based activities, which are exceptional, the youths have the option to participate in worship services or alternative activity will be provided if client does not wish to participate. The following involvement with CINS/FINS services is made available to the client and families: case staffing committee, CINS petition, and CINS adjudication. None of the (6) files reviewed were in need of staffing by the case staffing committee.

### 2.02 Needs Assessment

Satisfactory

Limited

Failed

#### Rating Narrative

The provider's policy and procedure states that every youth will complete a comprehensive Need Assessment which is initiated within seventy-two (72) hours of the residential intake assessment or within 2 to 3 face to face contacts for non-residential youth. The information that is obtained on the assessment includes social, emotional, educational, health behavioral, substance abuse, employment, abuse/neglect/exploration, family history, DCF/WHFS history, suicidal thoughts or history, and drug history.

Six (6) files were reviewed for three (3) open non-residential case management files and three (3) closed residential files. All three (3) residential files had a Needs Assessment completed within seventy-two (72) hours of intake and the Needs Assessment for the three (3) non-residential files were completed within 2 to 3 face-to-face visits.



The six (6) files have signatures for both the client and counselor/case manager completing the assessment and the supervisor; however, (3) residential files were missing credentials for the counselor/case manager. The six (6) assessments had the appropriate documentation noted on the assessment form.

Two (2) client files were identified with risk of suicide as a result of the Psychosocial (NEED) Assessment. The clients were referred for an assessment of suicide risk conducted by a licensed mental health professional.

Exception:

The credentials for the counseling/case management staff is not documented after their individual signatures on the Needs Assessment.

### 2.03 Case/Service Plan

Satisfactory

Limited

Failed

#### Rating Narrative

The provider's policy and procedure states that for every youth receiving services, a service plan is created to help assist the youth and/or family in reaching goals. The policy and procedure also states that a service plan is developed with the youth and family within seven (7) working days of the completion of the needs assessment process and is documented on the service plan. The policy and procedure states that a review of the service plan will be completed every fourteen (14) days throughout the duration of the plan to monitor progress towards achieving goals.

Six (6) files were reviewed for three (3) open non-residential case management files and three (3) closed residential files. The signature of the youth was indicated as "youth denied" in one (1) residential file and on two (2) files, no parent's signature was present but it was noted "reviewed with parent" by the counselor. All six files contained documentation of service plans. All six (6) service plans had initiation dates within seven (7) working days of the completion of the needs assessment. The six (6) plans also include: initiation dates, goals, frequency, type of services, location, person responsible, target date, and goals completed. All six (6) files documented case plan reviews every fourteen (14) days of initiation date of the service plan. All six (6) files have signature and dates of the completion of the reviews on each service plan.

### 2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

#### Rating Narrative

The provider's policy and procedure state that every youth that comes into the facility will be provided with the most appropriate services available to meet their identified needs. It is also stated that services will be available through referrals to in house services or services through other county providers, if needed. Additionally, all case management staff will assist youth and their families in preparing for planned exits or discharges from services and assist in identification of any aftercare and/or follow-up services that is needed or desired by the youth or family to ensure a successful transition.

Six (6) files were reviewed for three (3) open non-residential case management files and three (3) closed residential files. The six (6) files reviewed were all assigned a counselor/case manager. The counselor/case manager identified the youth/family referral needs and coordinated the referrals services based upon the on-going assessment of the youth/family's problems and needs. The service plan was implemented in all six (6) cases reviewed and the family was monitored in terms of their progress in the services received. The family was offered program/staff support; out of the home services monitored were documented in the case files. The six (6) files reviewed did not include any CINS Adjudication case staffing information but all documented case management services in the files with appropriate documentation of case monitoring with the exception of court hearings.

### 2.05 Counseling Services

Satisfactory

Limited

Failed

#### Rating Narrative

The provider's policy and procedure states that individual counseling for youth in crisis is a valuable tool for learning as well as for resolving crisis situations. Crisis counseling is available and provided, as needed, to youth who are involved in crisis situations such as fights, receiving negative information from home, etc. Individual counseling is conducted in the Residential Counselor's office (second floor) or the administrative conference room. The Group sessions are conducted by trained and experienced staff members at a minimal five (5) times per week basis. A variety of different topics are provided which enhances social skills, increases knowledge of health and medical issues, and addresses behavioral issues. Group sessions may also address a particular skill related to the Youth Development System.

All six (6) files reviewed documented progress notes in the appropriate section of the charts. The notes were in chronological order and all notes showed documentation of counseling services that were provided to the youth and the family.

## 2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

### Rating Narrative

The policy states that families and youth are provided a case staffing team meeting if the family or youth have not demonstrated substantial progress in achieving goals specified in the service plan, the services or treatment selected have not addressed the problems or needs of the family or youth, or the family or youth will not participate in services or treatment selected and/or more intensive services are needed or if requested by the parent/guardian. A case staffing may be requested by either an employee of the Florida Keys Children's Shelter or other participating service provider. The case staffing committee includes a representative of the youth's school district, DJJ and/or CINS/FINS, but not limited to a representative from the area health, mental health, substance abuse, social or educational services, state attorney and the youth and parent/guardian, and other person recommended by the child, family or CINS/FINS program.

In Truancy cases, a representative of the school system must be invited to attend. The case staffing committee is convened within (7) working days from receipt of the written request from the parent/guardian.

The (1) applicable Case Staffing file reviewed included case staffing letters, case staffing recommendation forms, court documentation and all case presentation documents are all present in the open file. It was noted that this youth has had a case recommendation in writing in the file with signatures and dates of everyone who were in attendance.

## 2.07 Youth Records

Satisfactory

Limited

Failed

### Rating Narrative

The policy and procedure states that a case record is maintained for each youth served. Each case record is organized in a consistent, professional manner and is stamped "Confidential". Confidentiality is maintained as case records are available only to program staff and persons legally contractually required to have access.

Any Florida Keys Children's Shelter client (youth or parent/guardian or placing agency case manager) wanting to review a case record makes a request through the Residential Coordinator, Residential Counselor, House Parent, Community Based Counselor, Counseling Service Coordinator or Project Lighthouse Director depending on services provided. The Chief Executive Officer makes a determination, including appropriate input from staff persons who had provided services to the client, whether it is in the best interest of the client to view the case record.

Six (6) files reviewed were all stamped confidential on the front/back cover of the files as well as on all the face sheets in each of the sections of the files. The records are maintained in a consistent manner and are neat and well organized so that staff can quickly and easily access information. The files are stored in a secure office at the shelter and in locked file cabinets for the community based counselors.

## Standard 3: Shelter Care

### Overview

#### Rating Narrative

FKCS is located in Tavernier, Florida and serves the entire Monroe County. The shelter provides residential services to youth in the Department of Juvenile Justice (DJJ) CINS/FINS program and is licensed by the Department of Children and Families (DCF) as a nineteen bed child caring facility. The shelter is designated and/or contracted by the Florida Network to provide staff secure, domestic violence respite, and probation respite services to youth.

During the tour, the facility was found to be in good working condition and the furnishings in good repair. Minimal graffiti was observed on one of the bedroom walls but none on the furnishings. The facility boasts tiled floors, professionally painted murals on the walls in the dormitories, new furnishing, exterior painting and well maintained landscaping. The shelter consists of a library/computer room, a large day room/dining hall, dormitories, a commercial kitchen, two laundry rooms, staff offices and a conference room. The dormitory, restrooms and common areas were clean. The dormitory is divided into two separate areas, one for the boys and one for the girls. The sleeping rooms house two youth each with an individual bed, bed covering and pillows. The most recently added bedroom contains three beds; the addition raised the number of beds in the facility to nineteen.

The youth have access to the game/recreation room, basketball court, and a nearby park. The Counseling Services Coordinator/CINS/FINS Counselor is a Licensed Mental Health Clinician (LMHC). Services provided include individual, group and/or family counseling, and any other applicable intervention required. The youth admitted to the program are screened using the Network Management Information System (NETMIS) Youth Screening Form, the CINS/FINS Intake Form, a brief FAM (Family) General Scale, and a Substance Abuse Subtle Screening Inventory (SASSI), when applicable. If a youth answers "yes" to any of the six questions pertaining to suicide risk on the CINS/FINS Intake form or if the staff member's observations of the youth's behavior would indicate any area of concern, an Assessment of Suicide Risk (ASR) is completed. The ASR is completed by either licensed professional or a non-licensed counselor under the direct supervision of the LCSW. A medical and mental health alert system is in place and the shelter staff that administers medications have been trained in the distribution of medication.

### 3.01 Shelter Environment

Satisfactory

Limited

Failed

#### Rating Narrative

The shelter has policies and procedures to ensure the shelter is clean and safe for the youth, visitors and staff. Upon arriving at shelter, the outside was well maintained and inviting. Vehicles were checked and were all found to be locked and secured. The 2 shelter vans were checked and both were equipped with first aid kits, fire extinguishers, and flashlight/glass breaker and seat belt cutter. Both had current registration and insurance cards. During the tour of the shelter, all doors were locked and secured. There were egress/evacuation plans posted throughout the shelter. Grievance forms are located in both girls and boys hallways. In the common area the abuse hotline, DJJ incident reporting number, rules, daily schedules (which include activities such as education, recreation, counseling, life & social skills, and at least 1 hour of physical activity), and menus are posted. All rooms appeared to be clean and well kept. The bedrooms were neat and orderly. The wall by one bedroom door did have some drywall/plaster missing due to the door being slammed by youths. Staff did state this is an ongoing problem and maintenance is aware it needs to be fixed. All beds had linens, blankets and pillows. The rooms that were occupied were personalized by the youth. The bathrooms were shared by two bedrooms and were clean and appropriate. All lighting was adequate for the areas and appropriate for youth activities. The only graffiti observed was in one bedroom on the wall mural and was pointed out to the residential program coordinator during the tour. The common areas were clean and neat as well with new furniture in the living room. The area was decorated for the holidays which made it warm and inviting. The kitchen area was clean as well.

The shelter inspections and dates are as follows: DCF licensing 2/1/14 to 1/31/15, Emergency plan review 12/5/14, Fire safety code inspection 11/5/14, Fire suppression system 1/24/14, Fire protection system inspection report 10/30/14, Health department food service inspection 10/22/14, Health department residential group care inspection report 10/30/14, and pest control is done bi-monthly with the last one being done on 10/17/14. No bugs or insects were observed during the tour of the facility.

There are 2 safes that youth may use to lock up belongings while in shelter: one is in the file room and the other is located in the Residential Program Coordinator's office. Both youth and staff have access to these.

The youth are offered opportunities to participate in faith based activities. If a youth chooses not to participate then another activity is planned for the youth which would be non-punitive. Youth are provided time to do homework and quiet time to read.

Exception:

The provider does an excellent job in conducting fire drills regularly, on every shift each month. However, two (2) of the drills (9/30/14 & 10/1/14) took 5 minutes, in excess of the two minutes required, according to the Fire drill record. It was noted by the residential coordinator on both of the drill reports that they took too long.

Medical drills are done on every shift each month. On 7/20/14 drill log shows 1 youth participating but drill report shows 10 youth participating. On 9/7/14 drill log shows 3 staff participating and drill report shows 2 staff participating. On 11/15/14 drill log time of drill was 11:55 AM, but on drill report it is 08:00. On 12/1/14 drill log time is 10:35 AM and on drill report it is 10:25 AM.

### 3.02 Program Orientation

Satisfactory  Limited  Failed

#### Rating Narrative

The shelter has policies and procedures that make sure the youth are oriented to the program within the first 24 hours after admission. At intake the youth are given a residential handbook which explains key staff and their roles, emergency evacuations, fire safety, facility tour, room assignment, contraband, daily schedules, dress code, hygiene practices, youths rights and responsibilities, grievance process, contacting abuse hotline and DJJ compliant hotline, medical care, mental health care, substance abuse services, visitation, telephone and correspondence procedures, rules and consequences and the shelters behavior management system.

Three (3) files were reviewed and all three (3) showed the youth received the orientation handbook at admission and had the resident handbook signature page which was signed by the youth and their parent/legal. Three (3) youth were surveyed of which two indicated receiving instruction of what to do in case of a fire and are familiar with the grievance process.

#### Exception:

One of the youth surveyed stated that s/he was not instructed on what to do in case of a fire and did not know about the grievance process.

### 3.03 Youth Room Assignment

Satisfactory  Limited  Failed

#### Rating Narrative

The shelter has policies and procedures in place that determine the youths room assignment as to protect the youth from threat of harm/violence and for the youth to feel safe and secure. The CINS/FINS intake form is completed which documents the youth's age, gender, height, weight, physical stature, gang affiliation, delinquency history, attitude at intake, physically or sexually assaultive/aggressive, medical, mental or physical issues, sexual abuse history, present or history substance use, runaway history and suicidal risk.

Three (3) files were reviewed and the CINS/FINS intake form was completed to determine room assignment. Alerts were put on the alert board in the staff office and, for each alert, a sticker was placed on the youth's chart. None of the 3 charts reviewed showed the youth having suicidal or homicidal history, gang involvement or gender identification issues. All 3 charts reviewed were signed by intake staff and a supervisor.

#### Exception:

On two (2) of the three (3) CINS/FINS intake forms, nothing was checked for the 6 history questions on the back. On 1 chart, substance use was checked and when the Reviewer asked staff about this, staff stated that if there is no history then nothing is put in this area. However, the 2 charts reviewed indicated the youth had tried substances on the front but nothing was checked on the back for the history questions.

Shelter policy states that staff members are made aware of youth classifications through documented log book entries and the medical/mental health alert systems. Reviewer spoke to two staff about entries in the log book and was informed that the only alert entered in the logbook was for suicidal precautions.

### 3.04 Log Books

Satisfactory  Limited  Failed

#### Rating Narrative

The shelter has a policy and procedure in place that ensures that routine and important information regarding the youths care and safety is documented.

Reviewer observed that all entries in the shelter's logbook were brief, legible and written in ink. At the beginning of each day, the number of

youth currently in shelter, scheduled intakes and discharges, and staff working that day on all 3 shifts is documented. All entries included the date, time of entry, brief entry on safety or security issues and signatures. Entries that were a safety concern were highlighted in yellow. Any errors that were made had a single line through them but some were missing staff's initial and some had "err" or "error" instead of void which is the shelter policy and procedure. Reviewer did not notice where any white out had been used. The logbook was reviewed by staff when arriving for their shift as well as the supervisor reviewing it once weekly and was highlighted in yellow.

### 3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

#### Rating Narrative

The shelter has policies and procedures in place that is designed to change the behaviors of the youth served which is essential in the program's operation.

The behavior management system has 3 levels: Orientation level, level I and Level II. The youth receives privileges for their level by receiving the minimum of 54 daily points. The youth may move up to next level when reaching their goals over time - 48 hours from OR level to Level I & 3 days from Level I to Level II. When the youth advances to a higher level, there are more privileges. Some of the privileges for the behavior system at OR level are telephone (official business only), television (scheduled time only), sport activities/board games & daily reading of orientation handbook. Level I privileges are the same as OR level plus video/computer games, passes and bus fares, facility outings, arts and crafts and shelter jobs. Level II privileges are the same as OR and Level I plus peer monitoring, volunteer work, canteen prizes, outside trips to store with staff, fast food restaurants and 1/2 cost of haircuts. Consequences are major infractions such as contraband, truancy, destruction of property, suspension or expulsion from school, assault, sexual activity or serious verbal threats. Minor infractions are: dress code violation, provoking other youth, inappropriate use of equipment, profanity and horseplay. The consequences do not deny the youths' rights or basic needs. Discipline is done by staff and no youth is allowed to discipline another youth. Room restrictions are not used at the shelter. The shelter uses the least restrictive intervention to ensure a safe environment. The system provides opportunities for the youth to work on self-esteem, leadership skills, and life skills training.

The staff are trained as part of their orientation and additional training is provided to ensure staff are using the system correctly and consistently. The residential coordinator provides feedback regarding compliance with the system and it's addressed as part of the staff's probationary and annual reviews.

Reviewer interviewed staff and some youth about the behavior management system. All agreed that the system is just and fair. Youth stated they wished that they would not "lose points" for some things like not getting up for breakfast on weekends if they did not want to eat. They also feel that the privileges are good.

### 3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

#### Rating Narrative

The shelter has policy and procedures in place that ensures adequate staff to youth ratio which provides safety for both the youth and staff. The shelter's staff schedule is posted in the staff office that is accessible to them. The shelter has a rotating on-call schedule with names and numbers of staff available for coverage if needed.

In reviewing the schedules it was observed that the shelter is meeting the standard ensuring that the ratio is 1 staff to 6 youth during awake hours and 1 staff to 12 youth during sleeping hours. The shelter also schedules at least 1 male and 1 female on each shift. The shelter has 24 cameras which were in working order during the review and the main monitor is in the staff office. Video storage can go back 30 days. The youth are observed at least every 15 minutes during sleeping hours. Video of room checks during sleep hours was reviewed. On 11/29/14 checks were being done within the 15 minute time frame but the time in logbook did not match time on video. On 12/9/14 the checks were being done within the 15 minute time frame and times in logbook were close to times on video.

#### Exception:

The time on the video did not match the time in the logbook on 11/29/14. Sometimes it did not appear that staff used real time when entering in the logbook because the entries appeared to be too exact, every fifteen minutes.

### 3.07 Special Populations

Satisfactory

Limited

Failed

#### Rating Narrative

The shelter has a policy and procedures in place that provide a higher security for staff secure youth. The provider had one (1) staff secure youth in the shelter during the onsite visit. The youth's file was reviewed and the assessments in the chart are the same as for the CINS/FINS youth, with no more comprehensive assessments for the Staff Secure youth. The youth chart has a court order that indicates that adjudication of the "child in need of services" will continue and the youth be returned to staff secure shelter for up to 90 days. The youth's service plan shows that it is being reviewed every week for progress. The youth is being drug tested weekly as stated in the court order. The service plan also shows that family is participating weekly via phone. There had been no visitations during the youth's stay due to distance between the family and the shelter. The youth is expected to have a 2 week home visit for winter break. The next report to the courts is scheduled for his next review which is set for 1/28/15.

The logbook was reviewed and it was evident that a staff member is assigned to the youth each shift. This entry in the logbook was highlighted in yellow.

Exception:

Staff secure youth do not receive more comprehensive assessments than the CINS/FINS youth in the program.

## Standard 4: Mental Health/Health Services

### Overview

#### Rating Narrative

The FKCS has specific procedures related to the admission, interviewing and room assignment of youth to ensure the safety and appropriate supervision of youth admitted into the program. Upon admission, Youth Support staff will interview youth and complete the intake. An initial intake 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 page 2 of the CINS/FINS Intake Assessment form.

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 licensed Clinical Coordinator or Program Coordinator 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 that discreetly mounted in the staff control room 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 the medication room in a double locked 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. Medication records for each youth are maintained in a binder.

### 4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

#### Rating Narrative

Agency has policy and procedures in place to ensure medical care for youth admitted with chronic medical conditions. The policy requires that each youth admitted receives a healthcare screening at admission. The healthcare screening is documented on the 2nd page of the CINS/FINS Intake Assessment form.

Three (3) youth files were reviewed. All three files contained a CINS/FINS Intake Assessment form. A review of the CINS/FINS Intake Assessment form in two (2) of the files showed they were incomplete and/or contained inconsistent responses to the questions.

For one of the youth, it was indicated on the CINS/FINS Intake Assessment form that the youth was not currently using or under influence of alcohol or drugs; however, it was noted that the youth was currently receiving services for substance use. Although the file indicated that the SPS was administered on 7/25/2014, the Intake form did not document that the SPS was administered where indicated on the form. Additionally, the Intake form indicated that the youth was currently taking medication; however, the medication that the youth was taking was not included on the form. Similarly, the health screening section of the Intake Assessment form was not completed for this youth.

#### Exception:

Two of the three CINS/FINS Intake forms reviewed did not have all of the information completed on the forms including the Healthcare Screening section which was blank in one of the three files. The SPS was administered for one of the youth; however, the Intake form did not document that the SPS was administered where indicated on the form, nor were the medications that the youth was taking noted on the form.

### 4.02 Suicide Prevention

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a comprehensive written plan that details the program's suicide prevention response procedures. The procedures are included in the Florida Keys Children's Shelter Comprehensive Master Plan.

In the review of three (3) youth files, all three files included the CINS/FINS Intake Assessment form which is used by the provider as a suicide screening tool. The suicide screening takes place during the intake process. The suicide screening results were signed by the supervisor and were maintained in the youths' files. Three youth were placed on the appropriate level of supervision based on the results of the suicide risk screening; however, it is noted that the suicide risk assessment for one of the youth was not completed within 24 hours after the screening. Youth was screened on 7/23/14 and the suicide risk assessment was completed on 7/25/2014. The Counselor advised that at the time the suicide risk assessment was initiated, the youth requested to complete the assessment the next day. Further, the youth was not placed on sight and sound until 7/24/2014 although the suicide assessment that was completed on 7/23/2014 contained a "yes".

Exception:

One of the three files reviewed, the suicide risk assessment was not completed within the 24 hours of admission. Also, the youth was not placed on sight and sound until 7/24/2014.

The Facility Supervisor/Program Director/Designee signature is not included on the Assessment of Suicide Risk.

#### 4.03 Medications

Satisfactory

Limited

Failed

##### Rating Narrative

Agency has procedures that address the safe and secure storage, access, inventory, disposal, and distribution of medications. Observation during this visit showed that all medications are appropriately stored in the medication room which is secured. Narcotic and controlled medications are stored in a double locked cabinet located in the medication room. Each youth's medication is stored in the double-locked cabinet in a zip-lock plastic bag.

At the time of this review, there were no injectable or topical medications. There were also no medications requiring refrigeration. However, the agency does have a locked refrigerator in the medication room for storage of medication that requires refrigeration.

There were no syringes at the time of the review. Sharps, razors and nail clippers are stored in a locked cabinet in the medication room. Only designated staff delineated in writing has access to secured medications. Staff designated to have access and administer medication have received training in Medication Management. The agency maintains a record of the last two trainings that were conducted in July and September 2014.

Inventory and running balances are maintained for controlled substances and OTC medication. OTC medication is inventoried weekly. Controlled substances are inventoried on a shift-to-shift basis with a running balance maintained.

Medication Distribution Logs are used to document distribution of medication to youth. Medical records for the youth contain the appropriate information required by the indicator.

#### 4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

##### Rating Narrative

Agency has written policy and procedures to ensure information concerning a youth's medical condition, physical activity restrictions, allergies, common side effects of prescribed medications, food and medication contraindication, and other pertinent treatment information is effectively communicated to staff through an alert system.

Three (3) youth files were reviewed. All three youth files contained evidence of the youth's placement on the program's alert system. Two of the youth had a medical or mental health condition or food allergy. Staff provided information regarding the alerts on the alert board in the staff station as well as in the youth's file.

Staff training files reviewed demonstrate that staff received training on Medical/Mental Health Alert Process.



#### 4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

##### Rating Narrative

Agency has written policy and procedures that comply with the requirements to ensure the provision of emergency medical and dental care. The agency's procedure includes the mandatory components for this standard.

Of the three (3) files reviewed, one (1) youth required off-site emergency medical services. The youth's transport was documented on a daily log.

A review of the training files document that staff have been trained on first aid and emergency medical care procedures. Emergency medical care is documented on the "Off-site Emergency Care Log" kept in the medication room and also noted in the log book and youth file.

Knife-for-Life and seat-belt cutters are located in the two (2) vans used to transport youth and in the monitoring room. Window breakers are also located in the two vans.

First aid kits/supplies are located in the medicine room and the two vans. First aid supplies were inventoried on 12/9/2014.