



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Florida Keys

on 11/03/2016

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 3: Shelter Care

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

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 4: Mental Health/Health Services

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

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

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

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

Satisfactory Compliance	Non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.
Not Applicable	Does not apply.

Review Team

Members

Marcia Tavares, Lead Reviewer, Forefront LLC

Jennifer Beckingham, Lead CINS/FINS Counselor, Lutheran Services Florida Southwest

Paula Friedrich, QI Monitor, Department of Juvenile Justice

Gregg Miller, Director of Programs, Lutheran Services Florida Southeast



Quality Improvement Review

Florida Keys - 11/03/2016

Lead Reviewer: Marcia Tavares

Linda Sessions, Program Manager, Tampa Housing Authority

Persons Interviewed

- | | | |
|---|--|---|
| <input checked="" type="checkbox"/> Chief Executive Officer | <input checked="" type="checkbox"/> Executive Director | <input type="checkbox"/> Chief Operating Officer |
| <input type="checkbox"/> Chief Financial Officer | <input checked="" type="checkbox"/> Program Director | <input checked="" type="checkbox"/> Program Manager |
| <input checked="" type="checkbox"/> Program Coordinator | <input checked="" type="checkbox"/> Direct- Care Full time | <input type="checkbox"/> Direct-Care Part Time |
| <input type="checkbox"/> Direct-Care On- Call | <input type="checkbox"/> Volunteer | <input type="checkbox"/> Intern |
| <input type="checkbox"/> Clinical Director | <input type="checkbox"/> Counselor Licensed | <input checked="" type="checkbox"/> Counselor Non- Licensed |
| <input checked="" type="checkbox"/> Case Manager | <input type="checkbox"/> Advocate | <input checked="" type="checkbox"/> Human Resources |
| <input checked="" type="checkbox"/> Nurse | | |
| 1 Case Managers | 0 Maintenance Personnel | 1 Clinical Staff |
| 2 Program Supervisors | 1 Food Service Personnel | 0 Other |
| 1 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 type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input type="checkbox"/> Fire Drill Log | 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 checked="" type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 14 # Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 7 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 3 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 7 # Youth Records (Open) |
| <input checked="" type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

2 Youth 3 Direct Care Staff

Observations During Review

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

Comments

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

Rating Narrative

Strengths and Innovative Approaches

Rating Narrative

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 variety 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 addition to the CINS/FINS Program, the agency operates the Poinciana Emergency Shelter (birth through 10 years) and Poinciana Group Home (11-17 years old) in Key West, for children who have been removed from their families/homes as a result of abuse or neglect. It also provides street outreach through Project Lighthouse where staff conduct outreach in areas where homeless youth congregate with the goal of getting these youth help and providing a safe shelter.

During the entrance conference, the reviewers were updated about the agency's achievements since the last onsite QI and Contract Monitoring visit in December 2015. A summary of youth and families served for FY 2014-2015 was highlighted in the agency's 2015 Annual Gratitude Report as follows:

131 Residential Clients

- Poinciana Emergency Home – 19 children
- Poinciana Group Home – 14 children and teens
- Jelsema Children's Center (CINS/FINS) – 98 children and teens

Community Based Clients

- Non-Residential – 417 youth/families
- Community based counseling – 165
- Project Lighthouse – 252

In April of 2016, the Florida Keys Children's Shelter (FKCS) was successfully 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.

Agency highlights during the past year includes the completion of another successful Mayor's Ball. The 14th Annual Mayor's Ball fundraiser, conducted in January 2016, drew the support of the Mayor and his wife along with other guests ranging from high ranking local officials to local businessmen. Another noteworthy fundraiser was conducted by a local 5 year old who after watching the news became concerned about homeless kids and wanted to do something to help. She raised \$600 from her lemonade stand and donated all the proceeds to the FKCS.

Congressman Carlos Curbelo visited the FKCS and presented the agency with a Certificate of Special Congressional Recognition for outstanding and valuable service to the community. Congressman Curbelo stated he was proud that the FKCS was awarded the U.S. Department of Health and Human Services 3-year Street Outreach Grant, totaling more than \$340,000.

Standard 1: Management Accountability

Overview

Narrative

FKCS has been in operations for over 30 years. The agency has a twelve-member Board of Directors/Trustees, including a youth member (with representatives from the upper, middle, and 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, a Chief Financial Officer (CFO), and Chief Development Officer (CDO). In addition, the program has licensed Mental Health Clinician (LMHC) on staff and a Shelter Program Coordinator. There was one staff vacancy (1 full time non-residential Counselor) at the time of the review.

At the time of the onsite visit, per the program roster, the shelter program staff included: a Program Coordinator, two Team Leaders, ten 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 Co-CEO. 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 inter-agency 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 current policy and procedures that address the background screening of all employees and volunteers. The provider's Policy number 1.12, last approved on 7/27/2016, requires all potential employees, volunteers who work alone with youth, and subcontractors to successfully complete a background check prior to an offer of employment or provision of service within the program and every five years subsequently.

The agency's 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 its 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 fourteen (14) background screening files were reviewed for eleven (11) new hires and three (3) employees who were eligible for a 5-year background screening since the last onsite visit. The fourteen new hire personnel had timely background screenings completed prior to their hire dates. Similarly, the 5-year re-screenings for the three applicable employees were completed prior to their 5-year anniversary dates. The program provided E-verify documentation for the fourteen new staff, verifying authorization to work.

A copy of the provider's Annual Affidavit of Compliance with Level 2 Screening Standards and email evidence it was submitted to the BSU on January 1, 2016 was provided and reviewed onsite.

No exceptions were noted at the time of the review for this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has comprehensive policies and procedures regarding: Code of Conduct (Policy #E.1), Employee Behavioral Expectations/Dress Code (Policy #1.10), Child Abuse Reporting, (Policy #1.07.01-1.07.03), and Grievance Process (Policy #3.22) to ensure the provision of an abuse free environment. The policies, last approved July 2016, require prompt, accurate, and timely reporting of child abuse allegations, prominent posting of the Abuse Registry phone number, and professional staff conduct.

Posting of the Abuse Hotline number was observed during the tour on a wall in the youth living room area. The Abuse Hotline number is also included in the resident handbook. The program's policy specifically complies with DJJ policies related to incident reporting, and requires 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.

The program also has a grievance 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. A grievance box is mounted next to the Residential Coordinator's office for depositing of completed grievances. Per the agency's procedures, completed grievance forms should be placed directly in the grievance box.

A review of three calls made to the abuse registry during the review period demonstrated that staff is aware of the reporting requirement; two of the three calls were accepted by the abuse hotline. None of the abuse incidents reported was institutional.

The program provided copies of 6 grievances filed in the facility during the review period. Four of the six 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.

Two youth were surveyed during the review. Both youth were familiar with the grievance process and indicated knowledge of the Abuse Hotline as well as the location of the number in the facility. None of the youth indicated that staff is disrespectful toward them or that adults in the program have ever used threats or profanity towards youth. Both youth stated they feel safe at the shelter.

Three staff members were also surveyed for this review. All three staff indicated that the working conditions were good at the facility and 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.

Per the QI requirement, Direct Care staff shall not handle the grievance document unless assistance is requested by the youth. The agency's policy and procedure requires completed grievances to be deposited into the grievance box but does not prohibit youth care staff from directly handling grievance forms. The policy and procedure was updated by the provider during the onsite QI review.

Two of the 6 grievances filed in the facility during the review period did not indicate whether or not the youth was in agreement with the resolution of the grievances as the appropriate check boxes were not marked by the youth who signed the grievance form.

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) and the 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 binders.

During the reporting period, six (6) incidents were reported, however, four (4) met the criteria and was accepted by the CCC. The incidents reported and accepted were as follows:

- 1) Shelter evacuation, due to hurricane "Matthew", the staff and youth returned two days later. There was no indication of a follow-up call or action.
- 2) Resident coordinator found a youth's medication (Adderall) on a desk in the youth's room. The youth claimed to have coughed it up shortly after taking it and forgot to give it back to staff. The CCC report confirms that the call made 30 minutes after the incident took place. A corrective action was taken and reported to the CCC.
- 3) CCC report confirms program staff called a report in at 10:03pm stating that a youth passed out. The youth was taken to a nearby hospital by paramedics, mother was contacted. The report CCC indicated that they initiated the follow-up report, not the agency.
- 4) Staff reported that a youth that is court ordered ran away with other youth.

The CCC confirms that all four incidents were reported to the CCC within 2 hours of the incident and/or gaining knowledge. All notifications and corrective action were handled as stated in the policy. Follow-up documentation was noted in two of the four incidents.

Several other internal incidents 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.

No exceptions were found at the time of the review for this indicator.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The Florida Keys Children's Shelter (FKCS) complies with QI standards, as evidenced by having a comprehensive written policy that addresses all indicators included in the Florida Network Operations Manual.

The FKCS training policy, which was last reviewed July 2016, includes information regarding the creation and maintenance of the training plan, first year requirements, on-going training requirements, and supervisory training. The policy also addresses training expectations for full-time, part-time and community based care staff. In addition, the policy included details about how staff training files are maintained, contents of the training file, exemptions from training, etc. Agency staff explained that staff is responsible for completing all foundational training within the first 120 days of employment. Staff submits certificates, sign-in sheets and/or curriculum as proof of any additional training completed outside of the required Florida Network training.

A total of eight (8) files were reviewed, three (3) in the first year of training, three (3) reviewed for evidence of in-service training, and two (2) specifically for evidence of counseling and/or management training. It appears that only one (1) of three (3) new files reviewed met the criteria for documentation of non-licensed mental health clinical staff training in assessment of suicidal risk. Per the agency's Co-CEO, the program's Licensed Clinical Supervisor and those residential staff certified as competent are the only staff used to conduct an Assessment of Suicide Risk (ASR). Since Non-licensed non-residential staff do not complete the ASR, the training requirements associated with this indicator are not applicable for these non-licensed counselors.

Seven (7) of the eight (8) files reviewed, met the requirements for first year and in-service training. All eight files had completed or were on target for completing the training hours and seven of the eight files included training topics required annually or had time to complete the necessary training. Each staff's training file was maintained orderly and in keeping with the agency's policy and QI indicator.

One youth support staff had not completed the PREA training since 2/13/14; refresher training was to be completed by 2/13/16.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedures that were reviewed and approved by CEO team July 7, 2016.

The policy for analyzing and reporting data outlining methodology for case record reviews, supervisory, and executive staff feedback was provided. A peer review is completed on both residential and non-residential programs on a quarterly basis. The Co-CEO reviews the incidents, accidents, grievances, staff surveys, outcome data, and monthly review of Netmis data reports. This information is reviewed at the staff meetings, quarterly Board meetings, and monthly leadership meetings.

There is a systematic record system for quarterly reports for case record reviews and risk prevention and

management. These reports are compiled and reviewed by management each quarter. Upon completion of each record review, the review team documents the findings on the File Review Form. The form is submitted to the Program Directors and Coordinators to review and address deficiencies. Program supervisors ensure appropriate follow-up is taken by their staff and responded to in a timely manner.

There is separate, detailed policy regarding incidents, accidents, grievances, service satisfaction surveys. There is policy regarding outcome data analysis as well as detailed procedures to collect, review, and to report various sources of information to identify patterns and trends. In addition, there is evidence that monthly leadership meetings are conducted where the executive staff and shelter coordinators discuss current concerns, progress, and other various topics. Some of the topics covered in the meeting are vacant positions, surveys, Florida Network data reports, and safety/risk management.

According to quarterly reports from July to September 2016, there were five (5) residential files reviewed (three (3) of them required a corrective action plan). For this same time period, twenty-six (26) CBC files were reviewed, of which three (3) required corrective action plans.

Consumer surveys are administered for staff and stakeholders annually and quarterly for youth in the program. A sample of twelve (12) satisfaction surveys were reviewed: seven (7) completed by parents, five (5) by youth. Eleven (11) of the surveys reflected positive reports; the one negative report was completed by a youth whose complaint referred more to the impact that the services had on the family dynamic and stated that they did not see much change.

Outcomes data is generated by the CEOs and included in the Providers Monthly Leadership Report.

NetMIS outcome data is also reviewed monthly and is presented at the Leadership meetings. 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.

Regarding the quarterly review for Risk Prevention and Management, it was reported that there were no medication errors or physical restraint during the months of July, August and September. The Annual Risk Prevention and Management report revealed satisfactory compliance status for COA (accreditation granted for four (4) years as of COA visit in April 2016) and satisfactory DCF licensing renewal received in May 2016. The Health and Human services audit, last conducted September 2013, was found to be in compliance and is set to be scheduled again in September 2017.

Regarding safety inspections, the annual fire inspection and evacuation plan review was last completed in November of 2015; the elevator inspection was completed September 2015; and the sprinkler system was completed 11/25/2015. Documentation in the annual report states that fire extinguisher was replaced in January 2016. Reporter verified via a letter, dated November 24, 2015 from the Captain of Prevention, that the shelter successfully completed the annual fire inspection. There was also evidence of testing of fire equipment. Reporter observed two fire extinguishers-- one in the dining area that was tested July 2016 and another by the front door and Residential coordinators office was tested last July 2016.

No exceptions were found at the time of the review for this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The program utilizes written policy and procedures that was reviewed and approved by CEO team on July 7, 2016. The agency client transportation policy considers immediate risk to run away or history of serious behavior on previous runaway and the number and gender of clients needing transportation. The policy states that the third party is an approved volunteer, intern, agency staff, or other youth. It also states that a cell phone must be available to the transporter whenever a van is utilized. It is noted in policy that the agency's practice is that a supervisor or managerial personnel will consider the client's history, evaluation, and recent behavior, when arrangements are made to transport that youth. Verification of this practice was confirmed by the residential coordinator.

The Residential Coordinator discussed their routine practice; which revealed that two staff is assigned to transport a youth and only in very rare cases is there only one staff. The Residential Coordinator stated that in the event that a second staff isn't available, a second youth is sent as a witness in case of incident.

Reporter reviewed van logs for the past three months which indicated that two staff signs the van log when a youth is transported. The log included date of service, client initials, priority of the transport (school, medical and other), time of transport and odometer readings. It was noted that some van logs required only staff initials, then some list first initial and last name.

The program Administrative Assistant (AA) provided documentation that lists all staff that are approved to drive the vans, as well as, a copy of the proof of insurance for the drivers. The AA provided three (3) personnel files containing copies of a valid driver's license for each employee. The AA explained that there is no system in place to monitor when licenses expire and should be updated. However, the provider's automobile insurance company annually completes driver's licenses checks for all covered employees as a practice.

In keeping with the policy, it was mentioned that the van is checked daily by the program staff, and a more thorough inspection is completed by the maintenance worker. The Residential Coordinator provided evidence that policy is being adhered to as it relates to staff receiving permission from a supervisor when a youth is either driven or walked to a location. This information is noted in the program's log book.

No exceptions were found at the time of the review for this indicator.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The program utilizes written policy and procedures that were reviewed and approved by the CEO team on July 7, 2016.

The policy states six (6) different ways that the agency uses to showcase/introduce services to the public through targeted outreach, working with local media, distribution of materials, public speaking, community needs assessments, and interagency agreements. A systematic record system is kept for all meetings and outreach events.

This reporter reviewed an Executive Council attendance sheet, which indicated the names of the board members and which months they attended their board meetings. Board meeting sign-in sheets and minutes were reviewed for June 2016 and August 2016 which indicated that the next meeting would be held October 20th.

The agency's Chief Development Director provided a list of more than twenty (20) outreach activities, where the agency was present, via staff/volunteer representation, program materials, radio broadcasts, meeting participation, etc. The public is encouraged to learn about the program through Facebook and the agency's website.

There is active volunteer participation; this is reflected in the tracking information maintained by the program administrative assistant. There was evidence of informational brochures and that the agency disseminates a monthly Newsletter that reaches approximately twenty-five hundred (2500) people or more. There was documentation regarding interagency agreements. The reporter reviewed thirteen (13)

interagency agreements with dates reflected from 2014 – 2016. The agency has been highlighted in the local newspaper on several occasions and has participated in live broadcasts with local radio stations.

No exceptions were found at the time of the review for this indicator.

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 conduct screening and immediately assess the needs of the family and youth. Residential counseling services are provided by Master's/Bachelor 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 (2 Master's and one Bachelor level staff) under the supervision of a licensed mental health clinician. 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.

The review of the charts shows that required documentation is in place. All services are being provided to the youth and families in a timely manner by the counselors and case managers. For the purpose of this review, four (4) randomly selected residential files and four (4) randomly selected non-residential files were reviewed. Of the four (4) residential files, two (2) of the files are currently open cases and two (2) are closed. Of the four (4) non-residential files, three (3) of the files are currently open cases and one (1) is closed. All files, both residential and non-residential, reviewed were marked confidential and are maintained in a secure file cabinet.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses the key elements of the QI indicator. The policy was last approved on 7/27/2016 and signed by both Co-CEOs.

All initial screenings are completed either at initial contact or within twenty four hours of admission using Netmis Screening and CINS/FINS Intake form. The interview process is used to determine eligibility, current problems, identify physical or mental health concerns. Policy identifies that youth who may be in crisis are identified and discussed with the Program Manager or Counseling Services Coordinator and will be provided with referrals. Screenings are completed within 7 calendar days of receiving the referral. All screenings are completed prior to or upon entrance in to admission. The parent/guardian is informed of youth's eligibility. If youth is not eligible, the Netmis Screening Form documents the reasons why and referrals made. Intake staff will provide referrals to alternative services if youth is not eligible.

A total of 4 residential and 4 non-residential files were reviewed. Four out of the 4 residential files and 4 out of 4 of the non-residential files contained screenings that were completed within 7 calendar days of the referral and were completed upon admission to the program. Four residential and 4 non-residential files contained a signed document stating that parents and guardians received the residential handbook, as well as the CINS/FINS brochure (which includes information for parents and youth regarding available service options, rights and responsibilities of youth and parent, parent/guardian brochure, possible actions through CINS/FINS Services, and grievance procedures).

No exceptions were found at the time of the review for this indicator.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses the key elements of the QI indicator. The policy was last approved on 7/27/2016 and signed by both Co-CEOs.

The agency's procedure states that the comprehensive needs assessment for youth who have open cases with the agency is initiated within 72 hours. The agency procedure states that the needs assessment will be completed for youth in non-residential care within two to three face-to-face sessions. The agency's procedure states that an updated Needs Assessment is conducted if the most recent assessment is over 6 months old or if information has changed significantly.

A total of four (4) residential files and four (4) non-residential files were reviewed. One (1) out of the (4) residential files reviewed contained a previous needs assessment completed within the last 6 months. The file contained a progress note stating the needs assessment would be used for the current admission, and updates would be completed if necessary. Three (3) of the four (4) residential files contained needs assessments that were initiated and completed within 72 hours of shelter admission. Four (4) of the Four (4) non-residential files contained Needs assessments that were completed within 2-3 face to face sessions.

Four (4) of the Four (4) residential files and four (4) of the four (4) non-residential files contained needs assessments that were completed by a masters or bachelor's level clinician, and were signed by a supervisor. Three (3) of the four residential files contained an indication of elevated suicide risk, and an Assessment of suicide risk was conducted by or under the supervision of a licensed mental health professional.

No exceptions were found at the time of the review for this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses the key elements of the QI indicator. The policy was last approved on 7/27/2016 and signed by both Co-CEOs.

The agency's policy and procedures 2.02, 2.03, and 2.04 address service plans and service plan reviews.

The agency's procedure states that the service plan is developed within 7 working days of the completion of the assessment process. All efforts will be made to engage the youth and parent in the service plan development and review. If the youth and parent are not present, unwilling, or refuses to sign the plan, such is recorded on the signature line of the plan. A case note entry is also made to indicate the reason for lack of a signature.

The service plan will address specific needs, appropriate services, completion time frames, persons responsible, problems identified, needs, the frequency and location of services, and achieved dates. The plan will be reviewed at 14 day review intervals.

Four (4) of the four (4) residential files and four (4) of the four (4) non-residential files contained case plans that were developed within 7 working days of the Needs Assessment. They all contained needs and goals, service type, frequency, location, persons responsible, target dates for completion, completion dates, signature of youth, signature of counselor, and the signature of supervisor. All files reviewed contained the date that the plan was initiated.

Three (3) of the (4) residential files contained reviews of the plan at 14 and 28 days. One (1) residential file was opened on 10/24/16; 14 and 28 day reviews were not due. Three (3) of the (4) non-residential files contained 14 and 28 day reviews. One (1) of the (4) residential files was discharged prior to a 14 or 28 day review was due.

One exception was noted. Four (4) of the four (4) residential files that were reviewed did not contain a parent signature on the case/service plan. The four files contained progress notes documenting that the parent and counselor reviewed the service plan but unavailability for the parent/guardian to sign the service plan was not documented on the plans.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The agency has policies and procedures (3.03, 3.04, 3.05, 3.06, 3.07, 3.08, 3.09) that address the QI indicator for Case Management and Service delivery. The policies were last reviewed on 7/1/16, 7/3/16, and 7/4/16.

The agency's procedure states that youth and families will be provided the most appropriate services available to meet identified needs. The agency establishes needs and coordinates referrals. The procedure states that discharge planning begins at intake.

Counselors coordinate service plan implementation and follow up regarding monitoring of progress and goals. The procedure states that follow up contacts will take place at 30, 90, and 180 days. Aftercare planning will include referrals to community-based counselors and agencies as needed. Agency procedure indicates that efforts are made to support and include the family in services. The agency's procedure indicates that family involvement takes place through family conferences, family outreach, and family counseling services.

Agency has procedures for the scheduling of case staffing committee meetings to take place within 7 working days of the request and to be implemented when the family and youth are not making progress. The procedure states that the youth and family are contacted within 5 working days of the scheduling of a case staffing committee meeting.

Four (4) of the four (4) residential files that were reviewed established youth's needs based on ongoing assessment of the youth and family's needs; coordinated service plan implementation, monitored progress, and provided support for families. None of the residential files reviewed were eligible to be referred to case staffing committee or needed court involvement. Two of the 4 residential files were opened during the time of the QI review and 2 of the 4 residential files contained case termination notes. Two of the

2 closed residential files had not been closed long enough to require 30 and 60 day exit follow ups. Reviewer was provided documentation in Netmis report showing that there are no outstanding 30 and 60 day exit follow-ups that have not been completed for the program. Two of the 4 residential files that were reviewed established and coordinated referrals based upon assessment of needs.

Four of the 4 non-residential files coordinated service plan implementation, monitored progress, and provided support for families. One of the 4 non-residential files had evidence of the monitoring of out-of-county placement and accompanying of youth and parent to court hearings, case monitoring, and review of court orders. Two of the 2 closed non-residential files had documentation of termination of the case and completed exit follow-up.

No exceptions were found at the time of the review for this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has policies and procedures that were last reviewed on 7/1/16 and 7/4/16 to address the QI indicator for counseling services.

The procedure for the program indicates that the shelter provides individual family and group counseling services. Agency policy states that presenting problems are reflected in the needs assessment and service plans, and that case notes are maintained in all youth files. The procedure indicates that case records are reviewed on a regular basis.

Four of the 4 residential files received counseling in accordance with the case plan. The youth's presenting problems are addressed in the needs assessment, case plan, and service plan review where required. One of the 4 residential files indicated that family counseling did not take place due to youth's refusal to participate.

Four of the 4 non-residential files indicate that youth and families receive counseling services according to case plan and individual counseling and that youth's presenting problems are addressed in the case plan, service plan, and case notes. All files reviewed indicated on-going internal process of clinical reviews and staff performance.

The group sign-in sheets were reviewed. Group was not provided 5 days per week for 4 weeks during September - November 2016. Staff interviews indicate that there are possible group activities taking place in the facility; however, groups are not being documented on a group sign-in sheet. Consequently, there are some weeks that did not show group conducted for 5 days although multiple groups were conducted on some days.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses the key elements of the QI indicator. The policy was last updated on 7/1/16 and 7/4/16 and signed by both Co-CEOs.

The agency's policy and procedure states that a case staffing committee will be scheduled if the family or youth do not have progress towards goals. The agency's procedure includes a representative of the youth's school district, a representative of DJJ, and a CINS/FINS provider staff, and other as deemed necessary. A residential or community counselor is the chairperson of the committee. The case staffing committee is contacted within 5 working days of the staffing. If a written request is received requesting a

case staffing, the committee is convened within 7 working days.

A review was conducted for one adjudicated non-residential file, during the review period, which contained a referral to the case staffing committee. The one file reviewed identified the person who initiated the case staffing committee and provided notification within 5 working days of staffing. The case staffing committee included a local school representative, DJJ representative, and CINS/FINS provider.

As a result of the case staffing committee the youth was provided with an updated plan for services as well as a written report that was provided to the parent. There is indication in the file reviewed that the program works with the circuit court for intervention as evidenced by filing of a CINS adjudication and court reviews. The counselor's completed court documentation and reviews were contained in the file. The program indicates a weekly convening of committee members of the case staffing committee to discuss truancy in the community.

No exceptions were found at the time of the review for this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has policies and procedures that were last reviewed on 7/1/16 to address the QI indicator for youth records.

The agency's policy and procedures state that case records are maintained for each youth served. Each file is to be organized in a consistent manner. Confidentiality is maintained and files are only available to persons authorized to have access to the file. All active case files are marked confidential and are maintained in a locked cabinet. All community-based counselor case records are marked confidential and maintained in a locked file cabinet located in each community-based counselor's office.

Four of the 4 residential files and 4 of the 4 non-residential files were marked confidential and were kept in a secure locked room. The reviewer was shown locked, opaque containers that are used for file transport that are marked confidential. Four of the 4 residential and 4 of the 4 non-residential files reviewed were maintained in a neat and orderly manner.

No exceptions were found at the time of the review for this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

FKCS is located in Tavernier, Monroe County, Florida and serves the entire county. It provides services to youth in the Department of Juvenile Justice CINS/FINS program and is licensed by the Department of Children and Families as a nineteen (19) bed child caring facility. The license is effective through January 31, 2017. Through a contract with the Florida Network, the shelter is authorized to provide staff secure, domestic violence respite, probation respite, and domestic minor sex trafficking services to youth. The census during the onsite visit was very low (only 2 clients) and the provider has consistently operated at less than capacity for the current fiscal year to date.

The agency has policies and procedures in place to address all of the indicators in Standard 3. A tour of the facility revealed that it has a clean and well maintained facility with adequate accommodations for the clients which include bed linens and separate beds in each room, adequate furnishings, clean functional bathrooms and adequate lighting. The day room has several chairs and a television with a gaming system attached. Next to the day room is the dining area with an adjacent television room/library. In the middle of the facility, between the boys and girls wing is the observation area where the mentors and shift leads go about their duties. Also in the observation room is the monitors for the video surveillance system. The Florida Keys Children's Shelter is staffed by 9 full-time and one part-time Youth Support Staff in addition to 2 team leaders. The Residential Coordinator supervises the shelter program.

There are schedules generated for weekly activities and weekly school schedules. All fire extinguishers were updated and had valid inspection tags. Client rules, grievance procedures, rights and responsibilities, behavioral expectations, and important phone numbers for reporting abuse or incidents were posted in visible locations in the shelter for easy viewing for the clients. Both hallways were clean and painted with beautiful murals. The bedrooms and bathrooms were organized and well-kept. Clients' items were tidy and put away in an orderly fashion. Each client bedroom has exquisite murals painted by local artists.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has several policies that address indicator 3.01 including FKCS policy 1.16- Maintenance of the Building, 3.14 -Sleeping arrangements and room assignments, 3.15- Daily activity schedule, 3.16- Group sessions, 3.17 -Participation in religious activities, 3.18- Residential quarter/bathroom facilities, 3.19- Personal Hygiene, 3.20 -Linen and Towel distribution, and 3.21- Counseling meeting room space. These policies were last reviewed and approved in July 2016 and signed by the two Co-CEOs.

FKCS policy 1.16, as it relates to the maintenance of the building, outlines the internal policies as to how repairs are to be made, when weekly inspections are completed, and the schedule of maintenance of large appliances. FKCS policy 3.15, daily activity schedules, encompasses the requirements that youth have structured activities and are given the opportunities for religious activities and specialized treatment services. Policy 3.16- group sessions/house meetings- directly correlate to offering life skills lessons 5 days per week. Policy 3.17, Participation in Religious services and faith/community based opportunities, outlines the rights of clients to participate in services and prohibits consequences to be given should the client choose not to participate. FKCS 3.18, residential sleeping quarters/bathrooms and shower facilities, encompasses a majority of the standard as it relates to lighting, cameras, shower and bathrooms being fully functional and operational. It also dictates repairs are completed and done in a timely manner.

Health and fire safety equipment inspections are current. The Monroe County Health Department completed an inspection on October 18, 2016. The fire safety equipment was completed by Monroe County Fire equipment and dated July 7, 2016. Mid-Keys security completed it's annual inspection on October 27, 2016. The testing form indicated the facility needed an updated Co2 detector and a smoke detector.

According to the Program Assistant, the items are on back-order with Mid-Keys security. Cutler Bay sprinkler systems completed their inspection on August 16, 2016. The only thing identified was a corroded sprinkler head in the CFO's closet. The CFO made plans while the reviewer was on-site to address the issue.

Fire and emergency drills were completed as required by the standard. The reports are completed and then signed by the residential coordinator and kept in a log. Fire Captain Walter Mason wrote a letter on 11/24/15 reporting the agency completed their annual inspection. The facility appears to be in good repair and free of insect infestation. The grounds of the facility are nicely landscaped and well maintained. The bedrooms in the facility are visually pleasing and have themed murals that were painted by local artists. Each youth is given their own bedding and linen. There is a securely locked place for youth to store items within a safe located in the file room closet. Shelter schedules are posted throughout the facility and the youth are scheduled meaningful, structured activities which includes time for counseling, recreation, and groups which include social skill training. The youth are given opportunities to participate in religious activities.

No exceptions were found at the time of the review for this indicator.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The agency has several internal policies that address the standard including FKCS 2.06- Orientation to the program, 3.14 -Sleeping arrangements and room assignments, and 3.40- Contraband, Valuables and restricted items. These policies were last reviewed and approved in July 2016 and signed by the two Co-CEOs.

FKCS policy 2.06 states that all youth entered into the program receive an in-depth orientation which includes a review of staff members, building evacuations procedures, policies on contraband, a review of the daily schedule, room assignments, abuse hotline and or DJJ CCC hotline numbers, grievance procedures, a review of CINS/FINS service, procedures to access medical care, visitation schedule, telephone policy, behavior management and youth development.

FKCS policy 3.14 provides for information that must be considered in child placement.

Policy 3.40 provides for an outline of the Residential Handbook in addition to visual inspections of the youth and their belongings, documentation of the inventory of the youth's belongings, restricted items, and items in the youth's possession, and the removal of items that may be harmful or otherwise offensive.

The FKCS Residential Handbook provides a wealth of information which includes facility layouts, policies regarding behavior management and related consequences for non-compliance, key staff, rights and responsibilities, privacy of information, grievance procedures, consumer rights and responsibilities, a copy of the chore list, abuse registry and DJJ CCC phone numbers, in addition to the shelter food menu.

The youth and parent sign a document attesting that the handbook and its contents were explained and that they understand the information contained within.

Five residential youth files were reviewed. All five youth received adequate program orientation that included receipt of the resident handbook, explanation of disciplinary actions, grievance procedures, emergency/disaster procedures, contraband rules, a tour of the facility, and room assignment. Signatures

of the youth and parent/guardian were present in all five files during intake. There was also evidence that the daily activity was reviewed with the youth and each youth received information regarding the Abuse Hotline number.

No exceptions were found at the time of the review for this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

FKCS policy 3.14 correlates to the DJJ Indicator 3.03. The policy, approved in July 2016, fully addresses the indicator and includes a process for initial classification of the youth for the purposes of room or living area assignment.

Policy 3.14 states staff must take the following into account prior to making a room assignment: clients physical characteristics, observed level of maturity, gang affiliation, current alleged offenses, previous delinquency history, levels or degrees of previous violent behavior, suicide risk, sexual aggression history, runaway history, substance abuse, and requires the separation of violent from non-violent youth.

According to the internal policy, the youth's behavior, attitude and history are documented on the CINS/FINS intake form. This was observed on the Florida Network of Youth and Family services CINS/FINS intake form on page 2 for all five youth files reviewed. Room assignments are noted on the bottom of the second page and reviewed by the residential coordinator.

No exceptions were found at the time of the review for this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

Standard 3.04 is addressed in FKCS policy and procedure 3.47. The FKCS policy requires use of the log book to provide for a permanent record of the residential program.

FKCS requires documentation of the daily activities, events, and incidents where the safety and security of a client is compromised in the logbook. All entries are to be brief and recorded by time of day. All errors are to be struck through with a single line. The program director reviews the log book and makes notes for needed follow-up or correction. The log book also documents any changes in youth's health status, appointments, discharge, head counts, or newly admitted youth and pertinent pass down information.

The log books were reviewed from 6/15/16 until current. The notes were concise and legible. There were several incidents with errors being scribbled out instead of drawing a single line through the error with the recorder's initials. Otherwise, the program staff completes entries on-time, the entries are legible and the book is reviewed weekly by the program coordinator.

There were several incidents where staff scribbled out entries instead of correcting the error as required by

the policy and procedure dictating they are to be corrected by one single line and initials.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

Florida Network Behavior Management Strategies are outlined in FKCS policy and procedure 3.26, Behavior Management and Youth Development System, in accordance with the QI Indicator.

The FKCS policy is designed to change the behaviors of the youth served and FKCS finds this is essential in program operations. The shelter utilizes a points and level system. The point system requires the shift to provide points for the youth on a daily basis. Clients can obtain anywhere between 0-6 points depending upon their performance with 0 points being awarded for poor behavior and 6 points being awarded for exemplary behavior and school work. Youth can earn up to an additional 3 points for completing extra chores, assisting with new client orientation, or taking the initiative to assist with a special project. In this system the points are usually given by shelter staff and the additional points can be obtained with the shift leader. There are 3 levels in their level system and there is an orientation level which takes 2 days and attainment of 54 points to move to level 1. From level 1 to level 2 the child must attain 64 points for 3 days to be able to make that level. Each level comes with assigned privileges and goals. For instance a youth on level 2 is to serve in a leadership capacity while in the program.

The level system includes incentives which include the option to actually earn money for completing shelter jobs. The Mentors and Shift leaders are responsible for monitoring and assessing the youth's behavior and assigning the appropriate number of points. The Residential Program Coordinator reviews the point sheets weekly and ensures the youth receive the appropriate monetary payments should they have been earned.

No exceptions were found at the time of the review for this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

FKCS has a policy which directly relates to 3.06 and its requirements. FKCS policy 1.15 requires adequate staff to youth ratios to ensure optimal supervision of the youth.

The residential program coordinator is responsible for creating and maintaining a staff schedule and ensuring that Florida Administrative code regarding 1 staff to 6 youth ratio on days and 1 staff to 12 youth during night sleep time. The policy ensures that when possible there is a staff member on shift which represents the make-up of the youth within the shelter. The shelter roster is provided to staff and hung in the monitoring station. In addition, it dictates youth are to be seen once every 15 minutes in cases where youth have been identified as high risk or on suicide risk.

The schedule is created by the residential coordinator and posted in the observation room. There is an on-call roster, which provides for at least 2 staff for each shift. Most second shift schedules provide for 3 staff members. There have been times during the review period where the shelter has been staffed during the overnight shift with two females instead of a male and female. The residential services coordinator was able to provide credible proof that FKCS did attempt to make contact with several males and they were unable to ensure both genders covering the overnight shift.

The shelter has 24 cameras and as of the date of the onsite visit, storage can go back 30 days. A review of the video recordings was conducted randomly for the 15 minute bed checks. The bed checks were found to be consistent with the documentation in the logbooks.

Exceptions were noted on some of the overnight shifts where the program did not provide coverage of staff who were the same gender as youth in the program.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The shelter has a separate policy and procedures in place for each special population youth as follows: Domestic Violence Respite (3.13), Staff Secure (3.13.1), Probation Respite (3.13.2), and Domestic Minor Sex Trafficking (3.13.3). All of the aforementioned policies and procedures were last approved on 7/27/2016.

Florida Keys Children's Shelter accepts youth who are court ordered in to staff secure services and approved by the Florida Network. Upon approval, the staff notates and highlights the entry of the staff secure youth and staff assigned on each shift in the program logbook. Written reports for any court proceedings are maintained in the legal section of the case file.

The program has applicable Domestic Violence Respite procedures in place for the provision of DV respite services. Per the P&P, youth placement are screened by the JAC/Detention will not exceed 14 days; however, the QI indicator provides placement for up to 21 days.

Probation respite policies and procedures are also in place that meets the requirement of the indicator.

Domestic Minor Sex Trafficking procedures in place at the time of the visit met the requirements of the indicator specifying approval by the FN prior to placement and for stays beyond 7 days as well as outlining appropriate services and level of secure supervision for youth.

For the review period, the program had provided services to one Staff Secure youth only and no other special population youth was served. The youth was adjudicated CINS/FINS and ordered to staff secure on 12/15/15. However, the program did not request and receive approval for staff secure services until the order was received from the court on 12/30/15. Approval as documented via emails to/from the Florida Network. The youth was on pass and/or runaway status for the majority of the time during the 2 month period ordered into care. During shelter stay, the name of the assigned staff was documented and highlighted in the logbook. The youth was Marchman Acted and shelter stay was terminated on 3/16/16, after receipt of court order for termination.

The policies and procedures for Staff Secure were missing procedures for parental involvement and collaborative aftercare, as required by the indicator.

Per the P&P, youth placement are screened by the JAC/Detention will not exceed 14 days; however, the QI indicator provides placement for up to 21 days.

Upon notification, the current P&P was updated onsite by the Co-CEO.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

QI indicator 3.08 is supported by the FKCS policy and procedures 4.13, entitled Perimeter Building Safety, in addition to FKCS policy 4.23 entitled Video surveillance and recording.

FKCS policy and procedure 4.13 ensures that the agency has adequate lighting and security monitoring cameras to prevent absconds and to document incidents and or injuries. Additionally the policies and procedures require playback capabilities of 30 days. FKCS policy 4.23 requires that the Co-CEOs or individuals approved by the Co-CEOs have the ability to view the cameras. In addition, supervisory reviews are conducted bi-weekly. Written notices of video surveillance are posted and no audio from the video cameras is enabled, if available, to ensure some level of privacy. Video surveillance according to policy may be released to third parties in cooperation with requirements of Federal, State, or local law enforcement agencies.

All cameras are easily visible both internally and externally. The surveillance system was observed during the site visit with the assistance of the residential coordinator. The system has at least 30 days of retention. The camera system is designed so that the reviewer was able to identify clients (facial recognition). According to the Co-CEO, the system has its own battery back-up supply for electrical outages. The camera system can be viewed off-site and is limited to the viewing of only one authorized employee which happens to be the Co-CEO. Although this was communicated to the reviewer, the provider did not have a list of designated personnel who can access the video surveillance system as required by the indicator. The residential services coordinator completes a review of the camera weekly and documents his reviews in a log.

A list of designated personnel who can access the video surveillance system is not maintained by the provider as required by the indicator.

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. If available, the contracted Nurse will complete the Health Screening during 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 professional 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 is 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 medications to staff during admission. Medications are stored the PyxisMed-Station 4000 Medication Cabinet located in the medication room. 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.

The program provides a full range of mental health and healthcare services to all youth in the program. The program has comprehensive policies and procedures (and a comprehensive master plan) that contains mental health, substance abuse, suicide prevention, crisis intervention and emergency procedures to ensure that the program staff follows the more appropriate practices to fulfill the youth's treatment needs. The program maintains an excellent partnership with the middle keys community and universities, and maintains interagency agreements with several local individuals and organizations that enhance the program's services. The residential area of the program provides every youth with a highly artistic, positive and therapeutic environment. There were no healthcare professionals in the program at the time of the review.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The program maintained policy and procedure number 7.01 to address health services. The policy was last reviewed and revised on 7/5/16 and last approved on 7/27/2016.

The program performs a preliminary physical health screening for each youth at the time of admission to the shelter. The agency nurse or direct care staff conducts the screening dependent upon who is available at the time of the youth's intake. The preliminary screening addresses current medications, existing acute

and chronic medical conditions, allergies, recent illnesses or injuries, the existence of current pain or other physical distress, observations for evidence of illness, injury or physical distress the presence of scars, tattoos or other skin markings. At initial intake, the residential nurse, if available, or residential staff will complete the intake form using information obtained from the youth, parent/guardian, the placing agency case manager and other interested parties. The completed intake form is to be reviewed by the residential nurse, if available, or if unavailable the assigned residential staff.

Youth are to receive preliminary physical and mental health screening at shelter admission. Youth admitted with ongoing medical care needs due to chronic conditions will receive ongoing medical care. Follow-up is required for any youth with asthma, a recent head injury, hemophilia, seizures or blackouts, a heart condition, tuberculosis, diabetes, or pregnancy. Additionally other identified conditions may result in ongoing medical care. Staff are to document and highlight needed medical referrals in the log book and the youth appointment book. Weekly review of the log book is to be conducted by the residential coordinator to ensure youth medical information is entered and highlighted, and any omission is to be entered via a corrected log entry.

Each youth admitted to the shelter receives a health screening completed by the shelter nurse or direct care staff. The program's health screening form addresses chronic medical conditions inclusive of diabetes, pregnancy, seizure disorders, cardiac disorders, asthma, tuberculosis, hemophilia and recent head injuries as well as high blood pressure; chronic pain, cough or headaches; eating disorders; gynecological, vision, hearing, kidney, skin, and digestive problems.

Three youth files were reviewed and each contained a completed preliminary healthcare screening identifying each youth's healthcare concerns. Documentation evidenced youth on current medications, with allergies, and observed with tattoos. No youth in the program during the review period had any chronic conditions, therefore no instances of follow-up medical care were reviewed, although the program nurse was able to state the program's procedure for referring youth for follow-up medical care for chronic conditions.

No exceptions were found at the time of the review for this indicator.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The program maintained policy and procedure number 4.14 to address suicide assessment and precautions. The policy was last revised on 12/11/14, last reviewed on 7/7/16 and last approved by the program's Co-CEOs on 7/27/2016.

The program's policy references the program's written comprehensive master plan, which addresses elements of suicide assessment, precautions and prevention. The suicide risk screening is completed as part of the intake process with additional assessment as warranted. The assessment of suicide risk is conducted by a licensed mental health professional or a non-licensed mental health clinical staff person working under the supervision of a licensed mental health professional. Youth in shelter awaiting an assessment are placed on constant sight and sound supervision with a staff person specifically assigned to the youth. All observations of any youth on heightened supervision are documented in progress notes.

The plan details notification procedures of the Co-CEOs, counseling services coordinator, residential coordinator, program supervisor, residential counselor, law enforcement and the parent/guardian. The program's referral system for youth at high risk of suicide includes law enforcement or licensed professionals qualified for Baker Act screening related to suicide prevention/response.

There were two files applicable for CINS youth with assessments of Suicide Risk completed during the review period. Both youth were screened for suicide risk during the initial intake and screening process.

Both youth were placed on sight-and-sound supervision until assessed by a licensed professional or a non-licensed professional under the supervision of a licensed professional. Documentation evidenced the two youth were placed on the appropriate level of supervision based upon the results of the suicide risk assessment. Staff documented both youth's behavior at least every 30 minute or less on the precautionary observation log sheets.

The program's policy and procedure differ from the requirements of the Network in that suicide risk screenings of suicide risk occurring over the weekend (after 5:00pm Friday through 9:00 a.m. Monday) may have the assessment of suicide risk completed within seventy-two hours, while the network requires those assessments to be completed "the morning of the first business day."

Two applicable files were reviewed and one of the two reviewed Assessments of Suicide Risk was not signed or dated by the facility supervisor to indicate a review of screening results was completed.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The program maintained policy and procedure number 3.41 to address medication distribution and storage. The policy was last reviewed on 7/4/16 and last approved by the Co-CEOs on 7/27/2016.

The program's written procedure requires the program to:

- Verify and document the verification of prescription medication with the pharmacy.
- Store all medications in the Pyxis med-station which should be inaccessible to youth.
- The program must have two supervisors for the med-station.
- Store oral medications separately from injectable and topical medications.
- Utilize a secured refrigerator only for the storage of medication with storage temperature requirements.
- Store controlled medication in the med-station.
- Allow only staff designated with user permissions to have access to secured medication and allow only limited access to controlled substances.
- Perpetually inventory controlled substances via witnessed shift-to-shift counts.
- Maintain a perpetual inventory for OTC medication which must be inventoried at least weekly.
- Secure syringes and sharps and document of weekly inventory counts the same.
- Utilize the Medication Distribution Log form to document distribution of medication by all staff.
- Conduct a review of medication management practices at least monthly via the knowledge portal or med-station reports.
- Verify medication via telephone contact with the pharmacy.
- Have the nurse conduct medication pass when the nurse is on duty.

All medications, including controlled medications, are stored in the Pyxis med-station which is inaccessible to youth. The agency verifies youth medications via telephone contact with the pharmacy inclusive of the name of the pharmacist with whom the verification was conducted. All medications are stored within the Pyxis med-station and the med station is stored in the locked medical office which is inaccessible to youth. The program has two super users for the med-station consisting of the nurse and

the shelter program coordinator. Oral medications are stored separately from both injectable and topical medications. The program maintains a secured refrigerator which is used only for the storage of medication. The program maintains a thermometer in the refrigerator to ensure adherence with storage temperature requirements and the refrigerator has a built in lock.

When on duty, the nurse conducts medication pass. Only staff designated with user permissions have access to the Pyxis med-station and limited access to controlled substances is maintained via a required electronic staff witness log in to the station. Controlled substances are perpetually inventoried as well as documented via witnessed shift-to-shift inventory counts. A perpetual inventory is maintained for OTC medication in both the Pyxis med-station and via a hand written log. OTC medications are inventoried weekly, typically on Mondays or Tuesdays, by the nurse. Syringes and sharps are secured and documentation of weekly inventories is maintained. The Individual Client Medication Distribution Log form is used to document distribution of medication by all staff to each youth.

The nurse completed training in the knowledge portal in August 2016; however, a monthly medication management practice review is not currently being conducted by the program via the knowledge portal or med-station reports as required by Network policy.

Further, the program's policy and procedures do not require monthly medication management practice reviews via the knowledge portal or med-station reports as is required by the Network.

The program's policy and procedure does not specifically address staff dispensing OTC medication to themselves; however, the program's practice is to allow staff to dispense OTC medications to themselves, while not indicating on the perpetual inventory the name of the staff for whom the medication was dispensed.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The program maintained policy and procedure number 7.03 to address the program's medical and mental health alert process. The policy was last revised on 1/14/2014, last reviewed on 7/7/2016 and last approved by the Co-CEOs on 7/27/16.

Information concerning a youth's medical condition, physical activity restriction, allergies, common side effects of prescribed medications, food and medication contraindication are effectively communicated to all staff through an alert system.

The alert system includes precautions concerning prescribed medication and medical/mental health conditions.

Staff are trained on how to recognize and respond to emergency care and treatment as a result of identified medical or mental health problems.

Suicide risk alerts are utilized to inform staff of needs which may require emergency care, assessment and treatment.

The program maintains a binder of the Daily Alert Report from each day as a reference of alerts active for each youth on each date of their stay in the shelter.

An interview with the nurse indicated staff are informed of youth alerts via verbal reports and by reading the intake documentation for each youth.

Three applicable files were reviewed and found to have a medical or mental health conditions or a food allergy. All three youth were placed on the program's alert system, which identifies precautions concerning allergies and special dietary restrictions, substance abuse, physical aggression, prescribed

medications, histories of sexual assault victimization, historical or current arson behaviors, runaway behaviors, and medical/mental health conditions.

Staff are provided information and instructions to recognize/respond to the need for emergency care for medical/mental health problems via verbal reports, logbook entries, intake documentation and the Daily Alert Reports which are posted on the interior of the monitor station door which is only accessible to staff.

The alert report observed posted on the inside of the master control staff office in the shelter at 4:45 pm on 11/2/16 was still the report for November 1st and had not been updated despite one youth having been removed from sight and sound observation the previous day (Nov 1st) at approximately 2:00 p.m. The program's policy and procedure calls for the listing of all youth alerts to be updated as needed; however, the programs stated practice is for the alert report to be printed once each day.

The file for one youth noted on the cover, the youth was on alerts for Mental Health, Health/medical concerns, Physical aggression and runaway behaviors; however, the Daily Alerts Report included him only for MH and HC from his date of admission on 9/11/16 through 9/20/16. The Daily Alerts Report for 9/21/16 added an alert for PA due to an incident on the 2-10 shift, which was continued on the daily report until his discharge on 10/28/16; however, the file notation of alert for runaway behaviors was never included on the Daily Alerts Report on any date during his stay at the shelter.

The Daily Alerts Report visually represents new residents by highlighting them yellow; however, newly added alert categories are not similarly visually noted or otherwise indicated on the report.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The program maintained policy and procedure number 4.19 to address emergency medical and dental care. The policy was last reviewed on 7/6/16 and last approved by the Co-CEOs on 7/27/2016.

The program's written procedure for emergency medical and dental care requires the program to obtain off-site emergency services for youth in need of urgent medical or dental care. Youth may be transported for off-site care via emergency transport by ambulance or by staff. All direct care staff are to be trained in first aid. Notification if the need for medical attention is to be made to the youth's parent/guardian as soon as possible.

An interview with the program nurse indicated it is the program's practice to complete an incident report for any incident requiring off-site care. The program's policy requires a log be maintained to document all off-site care and parental notification the same. The program's policy outlines both verbal and written reporting requirements, outlined in program policy 1.13, which requires incidents for youth classified as DJJ clients and meeting the criteria of DJJ reportable critical incidents to be reported to the Central Communications Center.

The program had only one instance during the review period of youth requiring off-site urgent medical care. Youth was transported for off-site care to the Mariner's Hospital emergency room. All direct care staff were trained in first aid. Notification of the need for medical attention was made to the youth's parent/guardian. An interview with the program nurse indicated it is the program's practice to complete an incident report for any incident requiring off-site care, although that is not specifically required by the program's written policy. The program maintained a log to document all off-site care, which included the date and time of the parent/guardian notification.

Verification of receipt of medical clearance, discharge instructions and follow-up care upon each youth's return to the shelter are not specifically addressed within the program's policy and procedure as is

required by the Network.

The closed file for one youth who received off-site care at the emergency room did not include the medical clearance, hospital discharge and follow-up care instructions although an incident report was completed and the CCC was notified of the transport to the hospital.