QUALITY IMPROVEMENT PROGRAM REPORT FOR

Sarasota YMCA

1106 South Briggs Avenue
Sarasota, FL 324237
(Local Service Provider)

Review Date(s):
March 27-28, 2012
CINS/FINS Rating Profile

Program Name: Sarasota YMCA CIN/FINS Program
Provider Name: Sarasota YMCA
Location: DeSoto, Manatee, Sarasota / Circuit 12
Review Date(s): March 27-28, 2012

QA Program Code: N/A
Contract Number: V2021
Number of Beds: 20
Lead Reviewer: K. Carr

## Indicator Ratings

### 1. Management Accountability

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.01 Background Screening of Employees/Vol.</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>1.02 Provision of an Abuse Free Environment</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>1.03 Incident Reporting</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>1.04 Training Requirements</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>1.05 Interagency Agreements and Outreach</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>1.06 Disaster Planning</td>
<td>Satisfactory</td>
</tr>
</tbody>
</table>

% Indicators Rated Satisfactory Compliance: 100%
% Indicators Rated Limited Compliance: 0%
% Indicators Rated Failed Compliance: 0%

### 2. Intervention and Case Management

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.01 Screening and Intake</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.02 Psychosocial Assessment</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.03 Case/Service Plan</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.04 Case Management and Service Delivery</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.05 Counseling Services</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.06 Adjudication/Petition Process</td>
<td>Satisfactory</td>
</tr>
</tbody>
</table>

% Indicators Rated Satisfactory Compliance: 100%
% Indicators Rated Limited Compliance: 0%
% Indicators Rated Failed Compliance: 0%

### 3. Shelter Care/Health Services

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.01 Shelter Care Requirements</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>3.02 Healthcare Admission Screening</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>3.03 Suicide Prevention</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>3.04 Medications</td>
<td>Limited</td>
</tr>
<tr>
<td>3.05 Medical/Mental Health Alert Process</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>3.06 Episodic/Emergency Care</td>
<td>Satisfactory</td>
</tr>
</tbody>
</table>

% Indicators Rated Satisfactory Compliance: 100%
% Indicators Rated Limited Compliance: 0%
% Indicators Rated Failed Compliance: 0%

## Overall Rating Summary

<table>
<thead>
<tr>
<th>Compliance Level</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfactory</td>
<td>100%</td>
</tr>
<tr>
<td>Limited</td>
<td>0%</td>
</tr>
<tr>
<td>Failed</td>
<td>0%</td>
</tr>
</tbody>
</table>
Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, and (3) Shelter Care/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2011).

Persons Interviewed

- **Program Director**
- **DJJ Monitor**
- **DHA or designee**
- **DMHA or designee**
- **3 Case Managers**
- **1 Clinical Staff**
- **0 Food Service Personnel**
- **0 Healthcare Staff**
- **2 Maintenance Personnel**
- **1 Program Supervisors**

Executive Director, Data Admin.

Documents Reviewed

- Accreditation Reports
- Affidavit of Good Moral Character
- CCC Reports
- Confinement Reports
- Continuity of Operation Plan
- Contract Monitoring Reports
- Contract Scope of Services
- Egress Plans
- Escape Notification/Logs
- Exposure Control Plan
- Fire Drill Log
- Fire Inspection Report
- Fire Prevention Plan
- Grievance Process/Records
- Key Control Log
- Logbooks
- Medical and Mental Health Alerts
- PAR Reports
- Precautionary Observation Logs
- Program Schedules
- Sick Call Logs
- Supplemental Contracts
- Table of Organization
- Telephone Logs
- Vehicle Inspection Reports
- Visitation Logs
- Youth Handbook
- Health Records
- MH/SA Records
- Personnel Records
- Training Records/CORE
- Youth Records (Closed)
- Youth Records (Open)
- Outreach
- Information, Disaster Plan, Netmis Data
- Surveys
- Youth
- Direct Care Staff
- Other:

Observations During Review

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

Comments

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

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

<table>
<thead>
<tr>
<th>Satisfactory Compliance</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited Compliance</td>
<td>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.</td>
</tr>
<tr>
<td>Failed Compliance</td>
<td>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.</td>
</tr>
</tbody>
</table>

Review Team

The Bureau of Quality Improvement wishes to thank the following review team members for their participation in this review, and for promoting continuous improvement and accountability in juvenile justice programs and services in Florida:

Keith D. Carr, Lead Reviewer, Principal Consultant, Forefront LLC  
Latrice Covington, Contract Manager-FNYFS, Office of Prevention and Victim Services  
Paul Czigan, CQA ASQ Government Analyst I, DJJ Bureau of Quality Improvement  
Cindy Kazawitch, Data Administrator, Youth and Family Alternatives, Inc.
Sarasota YMCA is a Child in Need of Services and Family in Need of Services (CINS/FINS) program operated by the Sarasota Family YMCA in Sarasota, Florida. The Sarasota YMCA agency has been in operation for more than 65 years. The agency’s programs impact over 70,000 lives through our four (4) fitness branches and offer more than fifty (50) youth and family development programs within 4 counties.

The Sarasota YMCA program serves male and female youth between the ages of ten to seventeen years that are status offenders (locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk). The program provides a full range of residential and non-residential services designed to maintain family structure, reduce truancy, as well as prevent and reduce the number of children that enter the Department of Juvenile Justice (DJJ) and the Department of Children and Families (DCF). Residential services provided include education, recreation, counseling, referrals, and behavior management components. The non-residential services program consist of individual and family counseling and case management services. The program is a designated Safe Place site. The Department of Children and Families has licensed the Sarasota YMCA Youth Shelter as a Child Caring Agency (CCA), with the current license in effect until May 31, 2012.

At the time of this onsite review, the Sarasota YMCA is currently undergoing physical plant renovations to its dining hall and kitchen.

The agency has recently completed trainings in January 2012 on Trauma Informed Care to increase and improve the ability of staff members to intervene and work to successfully address youth and families in crisis situations. The agency created a Quality Improvement Specialist in March 2012 to enhance the agency’s overall Quality Assurance/Improvement efforts.

The agency’s following staff members with professional licenses include Sonia Santiago, LMHC, Clinical Director, Kelly Gordon, LMHC and Marty McCoy, LMHC. There are two (2) additional staff members that are working towards the completion of their licensure which include Nicole Hartsock, LMHC and Danielle Glaysher-Kobin, LMHC (Intern).

The Sarasota YMCA is certified by the Council of Accreditation (COA). The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards. In addition, the agency participates in community involvement efforts by participating in Sarasota County stakeholders Coalition.

**Standard 1: Management Accountability**

The Sarasota Family YMCA is governed by a board of management which is comprised of approximately 15-25 community members who are dedicated to the advancement of the YMCA’s
mission to build strong kids, strong families, strong communities. A Metropolitan Board of Directors oversees the operations and strategic planning of the entire corporation. This board is comprised of chairpersons from the branch boards of management and community leaders. The Sarasota YMCA Board of Directors represent a vast cross section professions and industries.

John Halcomb, Executive Director oversees the youth and family programs and the services provided through its branches of services in Sarasota Florida service region. Additionally, the agency’s organizational chart lists Nicole Hartscock, Residential Program Director and Sonia Santiago, LMHC as the Non-Residential Program Director/Clinical Services Director. The agency also includes Fern Ellenwood, Assistant Program Director, Charles Harris, Assistant Program Director and Karen Mersinger, Quality Improvement Specialist. The agency counselors include Rasool Jackson, Residential Counselor and Kyamonie Wilson, Case Manager. The agency Behavior Coaches include Jason Jackson, Paul McLeod, Melissa White, Janice Swain, Karen Rapp, Jim Shea and Joann Fort. Direct Care staff members include Eric Young, Joe McCormick, Roy Jackson, Jenifer Bates, Richard Bates, Charlotte Oliver, Abby Flannigan, Shimona Jackson, Johnny Baker and Anthony McGurk.

<table>
<thead>
<tr>
<th>1.01: Background Screening of Employees/Volunteers</th>
<th>Satisfactory Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>The agency has a comprehensive policy that requires all prospective employees and current employees (5 year rescreens) to be appropriately screened. (See agency policy 1.01) A total of six (6) applicable personnel files were reviewed to verify and confirm the agency’s compliance regarding this standard. Of these files, five (5) were new/recent hires, all of which were properly screened and eligible to receive job offers. There was an additional file that was reviewed to assess the agency’s 5 year rescreen practice. This file was screened three (3) days prior to the staff person’s 5 year rescreen anniversary date. One (1) file is scheduled for a rescreen prior to October 27, 2012. All files reviewed also contain information that demonstrates that the agency conducts local background checks and driver’s license checks prior to hiring applicants. The agency has also demonstrated and provided evidence that the Annual Affidavit of Good Moral Character has been submitted to the DJJ Background Unit prior to the January 31 deadline.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1.02: Provision of an Abuse Free Environment</th>
<th>Satisfactory Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>The agency posts general information about the Florida Abuse Hotline contact numbers in common areas throughout the youth shelter. Abuse Hotline information is also contained in the client handbook. This book is provided to the resident during the admission process. The agency has a comprehensive policy regarding maintaining an Abuse Free Environment for clients and staff members. A total of five (5) agency Corrective Counseling Forms (Corrective Action Plans) were reviewed to assess the agency’s performance in this area. None of the CCF documents involved addressed significant presence or evidence of inappropriate or abusive behavior or behavior. A total of eleven (11) grievances and one (1) DJJ CCC incident were reviewed. These grievances all occurred since the last DJJ QA review. In general grievances are well documented and there’s evidence that the residential Assistant Program Directors are monitoring staff performance and professionalism of staff as a result grievances submitted by residents. Of these grievances,</td>
<td></td>
</tr>
</tbody>
</table>
certain cases center around two (2) specific staff members. Five (5) documented grievances are associated with one male staff member and four (4) associated with another male staff member. These cases later resulted in documented interventions by management to take necessary administrative and or disciplinary action. None involve any significant evidence of abuse, threats of harm or intimidation to youth.

1.03: Incident Reporting  
Satisfactory Compliance

The agency has a comprehensive policy and procedure regarding Incident Reporting. The agency’s policy specifies that the agency notifies the Department’s Central Communications Center (CCC) within two (2) hours of the incident, or within 2 hours of becoming aware of the incident. This policy was last updated in June 2011 and is signed by the current Program Director. As of the date of this review, there was only one (1) documented reportable incident. The review team also reviewed eleven (11) grievances and twelve (12) internal agency incidents. The DJJ CCC reportable incident that occurred in February 2012 and was reported as required and reported within the 2 hour time requirement. The incident involved and medication error committed by a staff person. The staff member was issued a documented disciplinary action or Corrective Counseling Form that is a formal agency practice to address inappropriate behavior, non or substandard work performance, etc. The agency management counseled the staff member in question and arranged re-training for the entire staff to address this issue. This training was coordinated with FNYFS and the DJJ Office of Health Services within 2 weeks of the incident.

1.04: Training Requirements  
Satisfactory Compliance

The agency has a training policy that requires agency staff members to address training requirements for all new hires and on-going full-time, part-time and on-call agency staff members. The policy was last updated in June 2011 and was signed by the current Residential Program Director. The agency handles all personnel functions through its Human Resources department located the Kane Office Building located a few miles from the youth shelter. This office processes all state and local background screenings and human resource functions. Annual training is tracked according to the employee’s date of hire. An individual training file is maintained for each employee, which includes supporting documentation such as sign-in sheets, training records and certificates. The provider agency conducts orientation training to all shelter personnel through a combination of training sources that include the Florida Network, local area and in-house trainers. Each employee has a separate training file containing training documentation. The system is designed for each to have a program orientation, a training plan and verification of training topics and courses completed for training received.

A total of six (6) new/recently hired files indicate that training has been initiated. The reviewer confirmed the completion of training for new hire Program Orientation, Medication Management and Delivery, Virtual Risk Management, Fire Safety, Child Sexual Abuse Prevention and Driver Training. As of the date of this review, some first year staff members do not have evidence that demonstrates that have completed CPR and First Aid training. The majority of new hires have time to complete required training prior to the close of each of their employment anniversary dates. At this time, the agency does not require new hires to receive priority training topics by a certain date such as within 30, 60 or 90 days of hire.

Of the four (4) On-Going staff member files reviewed all had evidence of CPR/First Aid training that was still in effect and 40 or more completed hours of training. The agency was advised of the five (5) new training topics offered online by the Florida Network of Youth and Family Services.
1.05: Interagency Agreements and Outreach

The agency has an internal policy on Interagency Agreements and Outreach. The review included assessing interagency agreements and outreach effects. Current written agreements or Memorandums of understanding are housed in a separate binder. The reviewer documented that the agency’s interagency agreements with agencies covering a variety of partner agencies. Staff members have evidence of participating in or conduct outreach at community events and meetings, other agencies, schools and the shelter monthly. At the time of this review, there was no evidence provided to determine if agreements or outreach efforts are being conducted in the DeSoto County service region. The agency has approximately forty-eight (48) interagency agreements. Most agreements are dated 2009 and some these documents are dated as being established in 2010.

The agency conducts outreach to 10-17 at several area events and at schools on a monthly basis. Some of the agency’s primary outreach efforts include presenting to the local police department to ensure that they are aware of the youth shelter and all Sarasota YMCA CINS/FINS services. The agency also attends the Safe and Drug Free School Advisory coalition meetings and the Sarasota County Juvenile Justice Council Advisory meetings on a monthly basis.

1.06: Disaster Planning

The program has a written Emergency Preparedness/Disaster and Emergency Plan to address the requirements as listed in standard 1.06 Disaster Planning. The current agency Disaster Plan was last revised in May 2011. The plan includes the minimum amount of disaster examples including water and nuclear accident/attack. Additional examples of disasters include chemical accidents and spills, Bomb Threats, Fire, Power Failure, Flooding or Flash Flood, Youth Riot, Taking of Hostages, Intruder or Shooter and Terrorist Act(s).

The current plan provides specific evacuation procedures for each disaster and the evacuation location. The current plan includes a supply checklist and accounts for adequate food and water supplies for residents and staff members.

The procedure for notifying the Florida Network of Youth and Family Services is at the front of the disaster binder as well as a phone tree for notifying all staff members. The current policy is documented as last revised in July 2011. The agency posts maps/egress plans in the dormitory areas and at specific exit points throughout the youth shelter. The program participates in the Universal Agreement for Emergency Disaster Shelter with the Florida Network Member Agencies.

Standard 2: Intervention and Case Management

Overview

Sarasota YMCA is contracted to provide both shelter and non-residential services for youth and their families in Sarasota and DeSoto Counties. The program provides centralized intake and screening twenty-four hours per day, seven days per week status offenders that include
runaways, truants, ungovernable and lockout youth. Trained staff members are available to
determine the needs of the family and youth. Residential services, including individual youth,
family and group services. Case management and substance abuse prevention education are
also offered on an as needed basis. Aftercare planning includes referring youth to community
resources, on-going counseling and educational assistance on an as needed basis.

At the time of this review, according to agency’s organizational chart lists Mrs. Sonia Santiago,
LMHC as the Clinical Director and Director of Non-Residential Services. At the time of this
review she oversees eight (8) staff members in the 2 aforementioned counties. Counselors are
responsible for providing case management services and linking youth and families to various
community services. The Family Counseling component or non-residential program is responsible for
coordinating 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. This component of
the agency also recommends the filing CINS Petitions with the court as needed.

<table>
<thead>
<tr>
<th>2.01: Screening and Intake</th>
<th>Satisfactory Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>A total of ten (10) client files were reviewed for this indicator. Of these files, five (5) were non-residential and five (5) were residential. All the files had a completed eligibility screening. Nine (9) out of ten (10) had evidence that the screening was initiated within seven (7) calendar days of the referral. Four (4) of the 5 non-residential files contained a checked and signed receipt of notice of Privacy Practice and Procedure. The form is proof that the youth and parents received written information regarding service options, youth rights and responsibilities, parent brochure, actions from involvement with CINS/FINS services, and the grievance procedures. Files reviewed under this standard indicate youth and parents/guardians received the available service options; rights and responsibilities of youth and parents/guardians information and parent youth brochure. Files reviewed contain a copy of the form indicating that this information was shared with youth and parents/guardians. Staff members provided the reviewer of this standard with a copy of the program’s Parent Handbook provided to youth and Parent Handbook provided to the parent at Admission/Intake. The handbook includes information and instruction on all program services, expectations and client rights. The Desoto County service region Outreach Plan for 2011-2012 was provided for review.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.02: Psychosocial Assessment</th>
<th>Satisfactory Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>A review of the agency’s policy and procedures for psychological assessment was conducted and was found to be inclusive of all components required by Standard 2.02. A total of ten (10) client files were reviewed to determine the agency’s adherence to this standard. Of these files, five (5) were non-residential and 5 were residential. All files contained psycho-social assessments that were initiated within the required timeframe. All psycho-social assessments were completed within two (2) or three (3) face-to-face contacts/sessions. All psycho-social assessments were completed by Master level staff members and reviewed by supervisors. Two (2) of the ten (10) files contained only pages 2 and 10 of the psycho-social document.</td>
<td></td>
</tr>
</tbody>
</table>
2.03: Case/Service Plan

Satisfactory Compliance

A review of the agency’s policy for case/service planning was conducted and was found to be inclusive of all components required by Standard 2.03. A total of five (5) files were reviewed to assess the agency’s adherence to requirements of this standard. Of these files, three (3) files were discharged (12/05/2011, 01/30/2012 and 03/2012) and two (2) are open.

All files followed Standard 2.03 requirements with the exception of 2 files. The target dates for completion were crossed out and replaced with new dates. However, the reviewer found no initials or dates were located near information that was crossed out and changed. This same file had completion dates missing on service Plan. An additional file is missing a psycho-social assessment date on the cover page. However, a counselor’s signature is present and does show a date (01/20/2012). The Supervision Log shows that a counselor needed to complete the psycho-social assessment.

The counselor for an additional file continues to conduct 30 day reviews after the first 3 months and the standards states every six (6) months thereafter. The agency demonstrates that processes and systems are in place for completion and performance requirements.

2.04: Case Management and Service Delivery

Satisfactory Compliance

A review of the agency’s policy and procedures for case management and service delivery was conducted and was found to be inclusive of all components required by Standard 2.04. A total of five (5) charts were reviewed to determine the agency’s adherence to this standard. Of these charts, three (3) were closed and two (2) were open. One (1) client was placed in family counseling and was closed on 01/30/2012. In this case the counselor conducted appropriate case management services according to the standard.

Two (2) files were referred to case staffing committee (CSC). Of these cases, one (1) client that was discharged on 03/12/2012 and another case that remains open and has a petition. The first client file indicates that the client was expelled from school and chose to attend virtual school, therefore the client was closed and had no further CSC involvement/activity. The second client was placed in family counseling and was closed on 01/30/2012. The counselor conducted appropriate case management practice according to the standard.

The reviewer was unable to review the 180 day follow-up requirement due to cases selected being less than six (6) months since their respective discharge date.

It is recommended that the agency include language into their Operation Policy and Procedure 2.04 stipulating what occurs when a youth is expelled from school and all options have been exhausted leading to discharge (during CSC involvement).

Processes and systems are in place for completion and meet general performance requirements.
2.05: Counseling Services

A review of the agency’s policy and procedures for Counseling Services was conducted to determine adherence to all by Standard 2.05. A total of five (5) client files were reviewed for adherence to this standard to assess if youth/families receive counseling services in accordance with the service plan.

Of the 5 files reviewed, one client has been unable to visit counselor due to mother cancelling due to doctor appointments. This file was very well documented by the counselor and numerous documented attempts were made to attempt engage and establish rapport with client and family.

Another file indicates that the guardian of the client was not involved in counseling services. However, the client is diligent about keeping weekly appointments and is still receiving counseling and shows progress.

Processes and systems are in place for completion and meet general performance requirements.

2.06: Adjudication/Petition Process

A review of the agency’s policy and procedures for the adjudication/petition process was conducted and was found to be inclusive of all components required by Standard 2.06. Of the five (5) files reviewed for this standard, two (2) file were school referrals for truancy. Both files notified the family and the Case Staffing Committee (CSC) of the meeting within the “no less than 5 working days prior to staffing” date. An additional file reviewed for this standard indicates that the client refused to cooperate with CSC recommendations. This youth was expelled and chose to attend virtual school therefore no petition was recommended and the file was closed (03/12/2012). The reviewer for the standard recommends that the agency see the recommendation made in Standard 2.04. The current standard 2.06 does not take into account these types of cases, therefore the agency followed the standard accordingly.

Processes and systems are in place for completion and meet general performance requirements.

Standard 3: Shelter Care/Health Services

Overview

Sarasota YMCA is licensed by the Department of Children and Families (DCF) for twenty (20) beds and it primarily serves youth from Sarasota and DeSoto Counties. The shelter also provides services to youth referred to them from the Department of Children and Families. The shelter building includes a common or day room, girls and boys dormitories, dining room, kitchen, laundry, staff offices and a multi-purpose/activity room. During the quality assurance review, the shelter was found to be in good condition and the furnishings in good repair, and the rooms and common areas were clean. The dormitories are divided into two areas separated by the common room for the boys and one for the girls. There are 2 bathrooms located near each dorm. The sleeping rooms house ten (10) youth each; each youth has an individual bed (bunk bed), bed coverings and pillows. In addition, the youth have access to a recreational games, volleyball court and basketball. This youth shelter is
not designated by the Florida Network of Youth and Family Services to provide staff secure services.

There are a total of twenty-four (24) Residential staff members (full-time, part-time and on-call) assigned to perform residential duties. This number of residential staff members includes one (1) Program Director, two (2) Assistant Program Directors and 2 counselors. The Direct Care workers are responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision. The youth care workers are responsible for processing new admissions, and providing orientation of youth to the shelter; the supervision of youth; and for maintaining inventories on all sharps and medications. Youth care workers also assist in the delivery of self-administration of prescribed and over-the-counter medications and administer first aid when needed.

Disaster plans, knife-for-life, wire cutters, and first aid kits are located in multiple locations throughout the facility, to include the staff station, medication room, and kitchen. All medications are stored in a locked cabinet in the direct care staff office. The program’s behavior management system consists of four (4) levels (Level 1, Level 2, Level 3 and Master Level). Youth start on the orientation level and advance up or down the levels depending on the total number of points accumulated each day; and privileges are based on the youth’s level.

Oversight of clinical services is provided by the Sonia Santiago, LMHC Clinical Director. The agency also employs other Licensed staff members. The program director is currently working towards completing her licensure. Youth admitted to the program are screened using the CINS/FINS Intake Form. If a youth answers “yes” to any of the six (6) questions pertaining to suicide risk on the CINS/FINS Intake form, an Assessment of Suicide Risk is completed. A medical and mental health alert system is in place.

3.01: Shelter Care Requirements

A review of the agency’s policy and procedures for screening and intake was conducted and was found to be inclusive of all components required by Standard 3.01. This policy is current and was reviewed and signed by the agency Program Director. The agency is not a staff secure program per their contract with the Florida Network of Youth and Family Services.

The agency policy does not authorize the Use of Force unless the safety of the child, or other children or staff is involved. The agency conducts annual training regarding this and utilizes the Techniques for Effective Aggression Management (T.E.A.M). The most recent training occurred on May 2011. There were no incidents, grievances, abuse reports or agency disciplinary examples or incidents involved the use of force over the last year.

A review of five (5) files were conducted to assess the agency’s adherence to this standard. All files reviewed possessed evidence that a comprehensive orientation was provided to each resident within 24 hours of admission. All youth were provided a handbook and advised of the agency’s grievance process. During this onsite program review, the review team located the grievance box with blank forms available to be completed by residents.

The agency’s policy requires bed check every (3.01C) ten (10) minutes. A review of camera surveillance tape was conducted. The monitor reviewed a random sample of 3 nights of bed checks from each of the last 3 days. The review revealed that the counts are being conducted as required, but a few of the bed check count times are off ranging for 3-5 minutes. One (1) staff
member’s documentation was not as exact regarding actual times documented as their co-workers on the same work shift. It is recommended that the agency ensure that the times associated with the surveillance camera are accurate. In addition, ensure that staff members are as accurate and documentation of times is complete when conducting bed check times. Exact and accurate documentation of the bed check count is equal to the actual performance of the duty.

3.02: Healthcare Admission Screening

Satisfactory Compliance

A review of the agency’s policy and procedures for screening and intake was conducted and was found to be inclusive of all components required by Standard 3.01. All five (5) current resident client files contained an intake form filled out the day of admission by a staff member. Most files were endorsed on the Supervisor line by the Administrative Assistant. Two (2) out of the five (5) made corrections related to current mental health or medications, but the date of or initials of the corrector were not noted. One (1) documented youth on psychological medication with a date seventeen (17) days subsequent to admission. However, the “No” was not indicated as the youth’s current condition on admission. None of the youth admitted had chronic conditions requiring a referral.

One youth required medical follow-up and parental conversations regarding medical appointments and medications were documented. None of the 5 files required an assessment of suicide risk (ASR) follow-up. Request more files.

All three (3) closed files reviewed revealed youth were placed on sight and sound supervision when answering yes to one of the first six (6) questions on the intake form. All 3 youth were referred for an assessment of suicide risk from the therapist.

One of the eight (8) youth required parental involvement with scheduling and coordinating Flu medical appointments, and this was documented in the file. None of the 8 file documented the youth had chronic conditions requiring notification or medical follow up.

3.03: Suicide Prevention

Satisfactory Compliance

The program had written policies and procedures related to Mental Health, Substance Abuse and Suicide Risk Screening, and Suicide Assessment. All three (3) closed files reviewed revealed youth were placed on sight and sound following answering yes on one of the first six questions on the CINS Intake form. All 3 case received an assessment of suicide risk (ASR) completed by licensed provider or a master’s level therapist receiving supervision by a licensed provider.

A qualified residential counseling staff member performed an assessment of suicide risk on a client. An additional ASR was performed on another client by a different staff member. Clinical supervision documentation was found for one staff, but not for the other.

The suicide prevention plan covers all the required areas. The program’s plan requires all staff members to receive four (4) hours of suicide prevention training annually. One file reviewed 4 hours of suicide prevention training annually. One (1) file reviewed by N. Hartsock documented SI Prevention 1.5 hours on 02/16/2012 and Suicide Risk Screening 1.5 hours on 07/14/10 totaling 3
hours, but not in the same year. At the time of this review, three (3) new hires; staff member 1 date of hire on 02/29/2012 had no documentation Suicide Prevention Training; staff member 2 date of hire 12/07/2011 had no evidence of Suicide training; and staff member 3 date of hire 11/12/11 also had no evidence of suicide training. Four (4) in-service staff members did have evidence of Suicide Prevention training.

3.04: Medications Satisfactory Compliance

A review of the agency’s policy and procedures for screening and intake was conducted. The reviewer assessed an incident a month ago regarding a wrong medication given and was reported to the CCC. In this incident a staff member recognized the error immediately and self-reported to administration. A corrective action investigation by Harry Motley was incomplete at this time. A corrective action began including onsite training of all staff members by the DJJ Office of Health Services. The training included an update of medication policy and procedures. Some follow up monitoring has continued since the incident on 02/03/2012 that resulted in staff discipline on 02/23/2012 of another staff for failure to follow proper protocol. However, monitoring oversight by administration should be continued for a period longer before this could be considered Satisfactory practice.

All current medication distribution logs contained all required information such as name, allergies, medication, prescriber, side effects, etc. All inventories were current including controlled substances, weekly over-the-counter medications, sharps, etc.

All storage protocols were followed as required including double locks form controlled substances. First aid kits (main office) had all required elements. The kitchen first aid kit had reduced supplies. The procedures for medication disposal were followed as recently as 06/23/11, but nothing in the prior 6 months.

3.05: Medical/Mental Health Alert Process Satisfactory Compliance

The agency has written procedures that were being followed consistently. These procedures include:

- Placing an alert form in each youth file and identifying the reason for the alert.
- Placing a red dot or red star on the spine of the youth file to identify medical (dot) on the Mental Health (star) alert.
- Place an applicable red dot or star in the appropriate column on the youth alert board in the common room of the shelter.
- Place a dietary alert for any applicable youth in the kitchen.
- Place a note in the logbook regarding the alert Green Dot on census board for youth on Sight and Sound supervision status.

At the time of this review, policies and procedures do not delineate the difference between the definition of the red dot and the red star.

3.06: Episodic/Emergency Care Satisfactory Compliance

The program had written procedures for "Emergency Mental Health and Substance Abuse Services."
current program procedures were found for pre-occurring emergency medical. The current policy addressed call 911 or transport youth if necessary. The policy and procedure also direct staff members to call parent/guardian initially and follow-up. However, no provision was found for emergency dental care.

The review observed four (4) drills, 3 for seizure (01/30/2012, 02/17/2012, 10/02/2011), and 1 for first aid scald/burn (10/27/2011). All were critiqued, however the first aid critique did not indicate the inconsistent application of ointment on the burn.

<table>
<thead>
<tr>
<th>Overall Rating Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfactory Compliance: 100%</td>
</tr>
<tr>
<td>Limited Compliance: 0%</td>
</tr>
<tr>
<td>Failed Compliance: 0%</td>
</tr>
</tbody>
</table>