



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of SM ACT Behavioral Health Center

on 10/12/2017

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	Limited
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

Percent of indicators rated Satisfactory:80.00%
Percent of indicators rated Limited:20.00%
Percent of indicators rated Failed:0.00%

Percent of indicators rated Satisfactory:96.30%
Percent of indicators rated Limited:3.70%
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

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC Cecelia Stalnaker-Cauwenberghs, LMHC, Director of Programs, Youth Crisis Center Mark Shearon, VP of Quality Assurance, Arnette House Toni Liebhart, Senior Counselor, YFA RAP House Mike Marino, Regional Monitor, DJJ

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 type="checkbox"/> Program Coordinator | <input checked="" type="checkbox"/> Direct- Care Full time | <input type="checkbox"/> Direct-Care Part Time |
| <input checked="" type="checkbox"/> Direct-Care On- Call | <input type="checkbox"/> Volunteer | <input type="checkbox"/> Intern |
| <input checked="" type="checkbox"/> Clinical Director | <input checked="" type="checkbox"/> Counselor Licensed | <input 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 | 2 Clinical Staff |
| 2 Program Supervisors | 0 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 checked="" type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Fire Drill Log | 5 # Health Records |
| <input type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 3 # MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 7 # Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 4 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 5 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 5 # Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

6 Youth 5 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 checked="" type="checkbox"/> Program Activities | <input type="checkbox"/> Tool Inventory and Storage | <input checked="" type="checkbox"/> Facility and Grounds |
| <input type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage | <input checked="" type="checkbox"/> First Aid Kit(s) |
| <input type="checkbox"/> Searches | <input type="checkbox"/> Discharge | <input type="checkbox"/> Group |
| <input checked="" type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings | <input type="checkbox"/> Meals |
| <input checked="" 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 agency moved their residential shelter on June 28, 2017 to their Tiger Bay facility. The shelter is now co-located with other programs run by the agency. The administration building of the facility was re-modeled to accommodate the shelter's needs.

The agency received a grant, Daytona Beach Racing Grant, that helped with the outside facilities of the program. Basketball courts were installed, as well as, shuffle board courts and a ropes course. The position of an Activities Director was added after the move to help facilitate outdoor activities with all the new equipment.

The shelter is also now able to use the services of another part-time Registered Nurse, in addition to their own, who was working for one of the other programs on-site.

Standard 1: Management Accountability

Overview

Narrative

Stewart Marchman ACT Behavioral Healthcare serves as the local service provider of Child in Need of Services and Families in Need of Services (CINS/FINS) in the Seventh Judicial Circuit that includes Flagler and Volusia Counties. The SMA Company provides both residential and non-residential services. The SMA Company is a current local service provider under contract with the Florida Network of Youth and Family Services to provide CINS/FINS services. This contract serves youth that are considered status offenders, homeless and lockout youth. These services include entry level of intervention and treatment for youth and families that are at risk for legal complications such as chronic runaway, lockout from the home or repeated school truancy.

The SMA company operates the SM Act Behavioral Health Center, a temporary youth shelter. The agency has a capacity of twenty (20) beds. A total of ten (10) beds are designated for youth that meet the eligibility requirements of CINS/FINS services. The SMA Company has been a Safe Place member and continues to be an official Project Safe Place site.

The management team consists of a Director of Adolescent Services, an Assistant Program Director, two Residential Shift Managers, three CINS/FINS Service Managers, one full-time Counselor, one part-time counselor, eleven Youth Specialists, an Administrative Assistant, one Case Manager, one Clinical Director, and two Outreach Specialists.

Training is provided through a combination of live in-person instructor led courses, web-based training topics, and various approved off-campus seminars. The program has a Human Resource Director who oversees all background screenings, as well as other personnel issues. The program provides family, mental health, substance abuse, and behavior management services. The program has current operations and program policies and procedures. Further, the agency also conducts outreach services through partnerships with local community stakeholders and various system partners.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy titled Background Screening of Employees/Volunteers. The effective date of the policy was listed as July 1995. The purpose identified for the policy is to ensure all employees and volunteers are properly screened before having access to youth. The policy was reviewed in August 2017 by the Director of Adolescent Services.

Program procedure requires the background screening process be completed prior to hiring an employee or utilizing the services of a volunteer. The procedure also requires that employees and volunteers are rescreened every five years of employment. The procedure requires an "Annual Affidavit of Compliance with Good Moral Character Standards" be submitted to the Department's Background Screening Unit by January 31 each year. (Note: the form has been updated to "Annual Affidavit of Compliance with Level 2 Screening Standards".)

Four newly hired staff and a nurse who was employed within the agency were reviewed for initial background screening. An initial background screening was completed prior to the date of hire date for the four new staff. For the nurse, a background screening was completed prior to her having access to DJJ youth. Two staff required a five-year rescreening, which was completed prior to and within one year of the anniversary of hire date for each staff. The provider submitted, by email, an Annual Affidavit of Compliance with Level 2 Screening Standards to the Department's Background Screening Unit on January 12, 2017.

There were no exceptions to this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory
 Limited
 Failed

Rating Narrative

The program has a policy titled Provision of an Abuse Free Environment. The effective date of the policy was listed as July 1995. The purpose identified for the policy is to ensure the program provides an environment in which youth, staff, and other feel safe, secure, and not threatened by any form of abuse or harassment. The program manual also includes a youth grievance process, which provides a means for youth to address staff with concerns if they feel their rights have been violated. The policy was reviewed in August 2017 by the Director of Adolescent Services.

The procedure for abuse free environment states staff adheres to a code of conduct that prohibits the use of physical abuse, profanity, threats, or intimidation. Youth are not to be deprived of basic needs such as food, clothing, shelter, medical care, and security. The procedure addresses mandatory reporting of suspected abuse, stating any person who knows or suspects a child is being abused must report it to the Florida Abuse Hotline. The procedure states management takes immediate action to address incidents of any form of abuse.

The grievance process includes informal, supervisor, and program director phases. The informal phase is for youth to try to resolve their complaint or condition by speaking to the staff on duty. If not resolved at the informal phase, youth write a grievance for the supervisor phase. The supervisor has 72 hours to investigate and render a decision regarding the grievance and inform the youth. If the youth disagrees with the supervisor, the grievance is elevated to the program director phase. The program director has 72 hours to review the grievance and issue a decision. The procedure is included in the youth handbook.

Grievance forms are available to youth in a binder attached to the living room door. The grievance process is posted above the binder. Within the binder is a grievance form in a clear plastic sleeve that includes instructions for youth explaining what is to be written in each section of the grievance form. The program has not had any grievances filed since the last review.

There have not been any abuse allegations made against any program staff since the last annual compliance review. Staff are trained on abuse reporting procedures upon hire. Logbook entries and internal incident reports showed program staff have contacted the Florida Abuse Hotline to report suspected child abuse based on reports/allegations made by youth about care takers or other adults.

Six staff were surveyed. All staff understood child abuse reporting procedures and reported they have never observed a co-worker tell a youth that they could not call the Florida Abuse Hotline. The staff also reported they have never observed staff using profanity, threats, intimidation, or humiliation when interactive with youth.

Eight youth were surveyed. None of the youth reported they had made an attempt to report suspected abuse or been delayed or stopped from reporting suspected abuse. None of the youth reported that staff were disrespectful when speaking with them or other youth. None of the youth reported ever hearing staff use profanity or threats when speaking with youth. Seven of the eight youth reported they felt safe at the program; the one youth did not indicate why he/she did not feel safe. When asked what to do in case they had a complaint about the shelter or staff, six youth stated they would talk to staff and/or fill out a form; two youth did not indicate how they would respond. When asked to rate the grievance process, two youth rated it as fair, two rated it as good, two rated it as very good, and two youth did not respond.

There were no exceptions to this indicator.

1.03 Incident Reporting

Satisfactory
 Limited
 Failed

Rating Narrative

The program has a policy titled Incident Reporting. The effective date of the policy was listed as July 1995. The purpose identified for the policy is that the program will properly notify the Department in regards to incidents. The policy was reviewed in August 2017 by the Director of Adolescent Services.

The procedure states the program will notify the Department's Central Communications Center (CCC) within two hours of a reportable incident or becoming aware of the incident. The also states the program completes follow-up communication tasks/special instructions as required by the CCC in order to close the case and assure the incident has been fully attended to as needed.

The program reported four incidents to the Central Communications Center (CCC) since the last annual review. Three of the incidents were related to medication errors. The remaining incident was contraband being found at the program. All incidents were reported within two hours of the program becoming aware of the incidents. Follow-up information was provided to the CCC as needed. All incidents were documented in the program logbook. Each incident was reviewed by the assistant program director.

There were no exceptions to this indicator.

1.04 Training Requirements

Satisfactory

Limited

Failed

[Rating Narrative](#)

The program has a policy titled Training Requirements. The effective date of the policy is listed as July 1995. The purpose identified for the policy is that staff receive training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions. The policy was reviewed in August 2017 by the Director of Adolescent Services.

The training procedure reflects the requirements listed in the indicator, identifying the required number of hours for staff. The procedure identifies required trainings be completed within 120 days for pre-service training, other trainings to be completed within the first year of employment, training to be completed in the Department's Learning Management System (SkillPro), and training to be completed annually following the first year of employment.

Training records for four newly hired staff were reviewed. Two of the staff have been employed over 120 days. These two staff had completed training in all required topics within 120 days. The remaining two staff are still within 120 days. Training records showed these two staff had completed most of the required trainings and still have over a month to complete the remainder of the training sessions required. Both of these staff were certified in first aid and CPR and had received training in managing aggressive behavior, suicide prevention, signs and symptoms of mental health, Title IV-E, medication distribution, ethics, confidentiality, child abuse reporting, and diversity.

The program's last annual review was in February 2017, thus training for calendar year 2016 was reviewed during that annual review, and found to be satisfactory. Five training records for staff in subsequent years of employment were reviewed for managing aggressive behavior, which was not completed by all staff in 2016. The five staff were also reviewed for newly required training to be completed in Department's Learning Management System (SkillPro). All five staff had completed an annual refresher in the Mandt System, which is the program's training for "crisis interaction, non-physical techniques and remaining calm at all times." Three of the five staff had completed the required trainings in SkillPro and the remaining two staff still have time to complete the SkillPro training in 2017.

There were no exceptions to this indicator.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

[Rating Narrative](#)

The program has a policy titled Analyzing and Reporting Information. The effective date of the policy is listed as July 2012. The purpose for the policy states the program collects and reviews several sources of information to identify patterns and trends. The policy was reviewed in August 2017 by the Director of Adolescent Services.

The procedure identifies eight different reports to be completed, which include monthly, quarterly, and annual reports required by the indicator. The findings of the reports are to be reviewed by management and communicated to staff. Improvements and/or modifications are to be made based on the reports and staff are to be informed and involved in this process.

Documentation showed all closed records are reviewed for each youth to determine compliance with various requirements or need for correction or updates. Documentation of monthly staff meetings showed incidents, safety issues or concerns, and statistical information/reports were addressed with staff and corrective action was addressed as needed. The clinical director provides weekly supervision to the non-licensed counselor. In addition, through the program's "Avatar" computer program, all work completed by the non-licensed counselor is electronically sent to the clinical director for review. The program has youth and parents/guardians complete satisfaction surveys upon discharge. In addition, staff complete thirty and sixty day follow-ups with youth/parents to see how youth are doing.

There were no exceptions to this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy that addresses client transportation. The effective date of the policy is listed as July 2016. The purpose identified for the policy is to avoid situations that put youth or staff in danger of real harm or perceived harm, or allegations or inappropriate conduct by either staff or youth. The policy was reviewed in August 2017 by the Director of Adolescent Services.

The procedure states agency drivers are staff approved by administrative personnel to drive clients in an agency or approved vehicle. All approved drivers must have a valid Florida driver license and covered under the company insurance policy. A third party is to go on transports, which can be another staff, a volunteer, or other youth. If a third party cannot be obtained for a transport, staff transporting a single client must have supervisory approval prior to transport and consent is to be documented.

Transportation logs were reviewed. The logs noted date, driver name, destination/purpose mileage, time in and out, the number of youth and staff on the transport, and vehicle performance comments. The number of transports has been reduced significantly since the program move to their new site, as youth attend school on site. There was only one instance of one staff transporting a single client; supervisory approval was documented in the logbook for this transport. It was noted, on occasion, that the logs reflected more youth on transports that were actually in the shelter. It was determined the transports also reflected youth from the RAP House, which is collocated with the shelter.

There were no exceptions to this indicator.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has policy addressing interagency agreements and outreach. The effective date of the policy is listed as July 1995. The purpose identified for the policy is for the agency to enter agreements in order to best serve families in the community. In addition, outreach services are to raise public awareness regarding CINS/FINS services and the ongoing issues of runaway youth. The policy was reviewed in August 2017 by the Director of Adolescent Services.

The procedure states interagency agreements allow for an interchange of information in order to serve clients in a cohesive manner. The agreements are to be reviewed annually and updated as needed. The procedure outlines three goals and objectives of interagency agreements and outreach in the community, which are: 1) Provide protection and safety for youth in need; 2) Assume leadership as a unifying force for community based prevention programs by drawing on community strengths and resources; and 3) Link information and services to assist children and families in trouble.

A binder is kept with all interagency agreements, safe place monthly statistics, community events, and agendas for meetings attended. There are several interagency agreements in place, which included agreements for/with alternative education, health care, mental health care, domestic violence services, a homeless shelter, and colleges and universities.

The agency employs an Outreach Coordinator, who is responsible for providing information about the program to the community. The Program Director attends the local DJJ Board and Council meetings and "One Voice for Volusia" meetings. The program director also serves as the chair for the local human trafficking task force. The program conducts an annual 5K race to raise funds and awareness for the program. The program participates in other community events as well.

There were no exceptions to this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Stewart Marchman ACT Behavioral Healthcare (SMA) provides an array of services including Centralized Intake and Non-Residential Counseling services. The non-residential staff members include a Licensed Adolescent Clinical Director, and three CINS/FINS Service Managers. Non-residential services are provided to program participants and their families. These non-residential services are delivered through the agency's non-residential component.

After intake, the program's Bachelor's or Master's level staff completes a biopsychosocial on each youth within 72 hours of admission or within two to three face-to-face contacts for youth receiving non-residential services. These biopsychosocials are reviewed and signed by a supervisor and, if there is a suicide risk component required, it is reviewed or completed by a licensed counselor. Within seven working days after the completion of the biopsychosocial, the program develops a case/service plan with the youth and family.

Each youth is assigned a counselor/case manager who will follow the youth's progress on the case/service plan to ensure the delivery of services either directly or through referral. Case/service plans are reviewed by the counselor/case manager and parent/guardian (as available) every thirty days for the first three months, and every six months thereafter, for progress in achieving goals and for making necessary revisions to the case/service plan, if indicated. Youth and families receive individual, family, and group counseling services, as set forth in their case/service plan, from program staff who document coordination between problems presented, and the youth's biopsychosocial assessment. Individual case files are maintained in accordance with confidentiality laws and notes kept chronologically to track progress. The program also has an established internal process to ensure clinical review of case records, case management, and staff performance.

2.01 Screening and Intake

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the elements of the CQI indicator. The policy manual was effective 07/2001 and last updated in August 2017 and signed by the Director of Adolescent Services.

The provider's procedure requires that Centralized intake services are available and accessible twenty four hours, seven days a week. Centralized intake services include screening for eligibility, crisis counseling and information, and referral. The initial screening for eligibility must occur within seven calendar days of referral by a trained staff member using the NetMIS screening form.

Beach House ensures that youth and parents/guardians receive the following in writing during intake; Rights & Responsibilities of youth and parent/guardians, available service options, possible actions occurring through involvement with CINS/FINS services, and grievance procedures. In addition, residents sign an Anti-Bullying Pledge and a review of values that are practiced in actions and words throughout Beach House; including; Compassion, Honesty, Accountability, Maturity, Respect, Education, and Dedication to Others. Beach House has a resident designed Youth Handbook cover page that states: "Welcome to Beach House...Bringing enrichment and children home".

A total of five non-residential files were reviewed. Two of the five files reviewed were closed files. All five files completed the eligibility screening within seven calendar days of referral. All five files indicated that youth and parents/guardians received the following in writing: available service options, rights and responsibilities of youth and parents/guardians, and a parent/guardian brochure. All files indicated that youth and parents/guardians have access to possible actions occurring through involvement with CINS/FINS services and grievance procedures.

A total of five residential files were reviewed; three open and two closed. All files reviewed demonstrated that an initial screening for eligibility occurred within seven calendar days of referral. With all but one occurring on the same day as Intake. All files reviewed demonstrated that youth and parents/guardian received in writing available service options, rights and responsibilities of youth and parents/guardian, program brochure, grievance procedures, and possible actions occurring through involvement with CINS/FINS services.

There were no exceptions to this indicator.

2.02 Needs Assessment

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the elements of the CQI indicator. The policy manual was effective 02/2001 and last updated in August 2017 and signed by the Director of Adolescent Services.

The provider's procedure requires that upon entry to the Residential Program, each youth shall receive a Needs Assessment initiated within 72 hour of admission. In the event that the most recent Needs Assessment that is completed is over six month old a new, full Needs Assessment will be completed. For non-residential services the Needs Assessment must be initiated during the first face-to-face session. Beach House's policy indicates that if identified on the Needs Assessment more intensive assessment or evaluations are necessary a referral will be made.

A total of five non-residential files were reviewed. Two of the five files reviewed were closed files. All five files indicated that the Needs Assessment was completed within two to three face-to-face contacts after the initial intake. The Needs Assessments were conducted by a Bachelor's or Master's level staff member. The Needs Assessment include a supervisor's review signature upon completion. All five files indicated that the youth were not identified as an elevated risk of suicide as a result of the Needs Assessment and were not applicable for the Assessment of Suicide Risk.

A total of five residential files were reviewed; three open and two closed. All five files reviewed demonstrated that a Needs Assessment was initiated within 72 hours of admission. All five files reviewed indicated that all Needs Assessment were completed by a Masters level staff member. Four of five files reviewed included a Licensed Mental Health Clinician completing the Needs Assessment and reviewed by a Supervisor. One of five files identified an elevated risk of suicide as a result of the Needs Assessment. At which point, a Suicide Risk Assessment was conducted by a Licensed Mental Health Clinician.

There were no exceptions to this indicator.

2.03 Case/Service Plan

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the elements of the CQI indicator. The policy manual was effective 02/2001 and last updated in August 2017 and signed by the Director of Adolescent Services.

The provider's procedure requires that each child/family eligible for and opened to CINS/FINS Service Management (Non-Residential) and Beach House Shelter services, shall have a formal service plan established between designated staff member, the child and the family, within seven working days of the assessment. They emphasize in their policy that the Service Plan is the "umbrella" document that ties together all the assessments, plans, goals, services, resources, and supports needed or desired by the individual and family. In addition, the case plan shall include the following:

1. **Specific Needs of the youth and family**
2. **Time frames for completion**
3. **Responsibilities of youth/family to complete goals.**
4. **The responsibilities of the program to assist the youth/family in goal completion are listed.**
5. **Measurable objectives that address the identified problems or needs**
6. **Services and treatment to be provided to include:**
 - Type of services of treatment
 - Frequency of service or treatment
 - Location and accountable service providers or staff

The agency provides an array of services that youth and family agree to participate by signing the service plan if necessary to include, but not limited to:

1. **Intensive crisis counseling**
2. **Parent training**
3. **Individual, group or family counseling**
4. **Community mental health services**
5. **Prevention and diversion services**
6. **Services provided by volunteer or community agencies**
7. **Runaway center services**
8. **Special education, tutorial or remedial services**
9. **Vocational, job training or employment services**
10. **Recreational services**
11. **Homemaker or parent aid services**

A total of five non-residential files were reviewed. Two of the five files reviewed were closed files. All five files had the Case/Service Plan developed within seven working days of Psychosocial Assessment. All five plans reviewed documented: the individualized and prioritized need(s) and goal(s) identified by the Psychosocial Assessment, the service type, frequency, and location for the Case/Service Plan. All five files had the person(s) responsible and the target date(s) for completion. All five files had youth, parent/guardian, counselor, and supervisor signatures, the date the plan was initiated, and were reviewed for progress/revised by counselor and parent every thirty days for the first three months and every six months after. Three files were not applicable for actual completion dates due to cases currently open. Two of the files had the actual completion dates.

A total of five residential files were reviewed; three open and two closed. All files reviewed demonstrated a Case/Service Plan was developed within seven working days following completion of assessment. All residential files indicated the Case/Service Plan goals were individualized and prioritized need(s) and goal(s) identified by the Needs Assessment. All files included signatures of youth, counselor, and supervisor. One of five files did not include the parents signature as the parent refused to participate in services with the youth.

There were no exceptions to this indicator.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the elements of the CQI indicator. The policy manual was effective 02/2001 and last updated in August 2017 and signed by the Director of Beach House.

The provider's procedure requires that each youth is assigned a counselor/case manager who will follow the youth's case and ensure delivery of services through direct provision or referral. The program staff will review the service plans at 30, 60, and 90 days after its initiation to assess progress in achieving goals and objectives depending on the length of stay the youth is in the shelter. Based on this review process, the program staff may: terminate the case as indicated by successful or substantial completion of the plan, advise the case staffing committee of the need to revise the plan, if applicable, or recommend to the case staffing committee that judicial action is to be taken, if applicable.

The provider's procedure also allows for the Service Plan to be updated when reviewed with the youth and family at major key decision points in the youth's course of service. These decision points may include but are not limited to the following:

- Time of admission, transfer, and discharge
- Major change in the youth's condition/situation
- Admission and discharge from a residential facility
- Participation in a Case Staffing Committee/FSPT/CRT

A total of five non-residential files were reviewed. Two of the five files reviewed were closed files. All five files had a Counselor/Case Manager assigned, established referral needs, coordinated referrals to services based upon the on-going assessment of the youth's/family's problems and needs, coordinated service plan implementation, monitored youth's/family's progress in services, and provided support for families. None of the files were applicable for monitoring out-of-home placement. All five files referred youth/family for additional services when appropriate and provided case monitoring and reviewed court orders. All five files indicated that staff accompanied youth and parent/guardian to court hearings and related appointments. The two applicable files provided case termination notes.

A total of five residential files were reviewed; three open and two closed. All files reviewed demonstrated that a Counselor/Case Manager was assigned at admission. All files reviewed demonstrated that the Counselor/Case Manager established referral needs and coordinated referrals to services based upon the on-going assessment of the youth's/families problems and needs, coordinated service plan implementation, monitored progress of services, and provided support to the families. None of the files required monitoring of out-of-home placement. Two of the five files indicated that additional services were necessary and appropriate referrals were made.

There were no exceptions to this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the elements of the CQI indicator. The policy manual was effective 02/2001 and last updated in August 2017 and signed by the Director of Adolescent Services.

The provider's procedure requires that youth and families receive counseling services in accordance with

the youth's service plan, to address needs identified during the assessment process. Residential programs provide individual, family, and group counseling. Group counseling sessions are conducted a minimum of five days per week. Non-Residential programs provide a therapeutic community-based services designed to provide intervention necessary to stabilize the family in the event of crisis, keep families intact, minimize out-of-home placements, provide aftercare services for youth returning home from the shelter services, and prevent the involvement of youth and families in the delinquency and dependency systems. Services are provided in the youth's home, a community location, or provider's counseling office.

The program policy indicates that when counseling services are provided, the following occur:

- Reflect all case files for coordination between presenting problems, bio-psychosocial assessment, case/service/plan case/service plan reviews, case management, and follow-up.
- Maintain individual case files on all youth and adhere to all laws regarding confidentiality
- Maintain chronological case notes on the youth's progress
- Maintain and on-going internal process that ensures clinical review of case records, youth management, and staff performance regarding CINS/FINS services

A total of five non-residential files were reviewed. Two of the five files reviewed were closed files. All five files had youth's presenting problems addressed in the Psychosocial Assessment, had youth's presenting problems addressed in the initial Case/Service Plan, youth's presenting problems addressed in the Case/Service Plan reviews, case notes were maintained for all counseling services provided and documented youth's progress. All five files had an on-going internal process that ensured clinical reviews of case records and staff performance, that the youth and families receive counseling services in accordance with the Case/Service Plan, and that the program provides individual/family counseling.

A total of five residential files were reviewed; three open and two closed. All files reviewed demonstrated the youth's presenting problems were addressed in the Needs Assessment, Initial Case/Service Plan, and Case/Service Plan reviews. All files contained case notes for all counseling services and included the youth's progress towards Case/Service Plan goals. Individual, family, and group counseling is completed by a Licensed Clinician or a Registered Mental Health Clinician under the supervision of a Licensed Clinician. Group counseling sessions occur in the afternoon seven days a week for a minimum of thirty minutes. Group counseling sessions included the following topics: Anger Management, Coping Skills, Relaxation Techniques, Alcoholism, Self-Esteem, and Hygiene.

There were no exceptions to this indicator.

2.06 Adjudication/Petition Process

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the elements of the CQI indicator. The policy manual was effective 02/2001 and last updated in August 2017 and signed by the Director of Adolescent Services.

The program has an established case staffing committee and regular communication with committee members. The program has an internal procedure for the case staffing process, including a schedule for committee meetings.

One of the five files reviewed completed a Case Staffing. The Case Staffing was initiated by the Service Manager. The family was notified of the staffing no less than five working days prior to the staffing. The

local school district representative was present at the staffing, as well as, the DJJ representative or CINS/FINS provider. The file indicated that mother and school social worker also attended the staffing, as well as, a mental health representative. As a result of the Case Staffing Committee meeting, the youth and family were provided a new or revised plan for services and a written report within seven days of the Case Staffing meeting, outlining recommendations and reasons behind the recommendations. The file indicated the program works with the circuit court for judicial intervention for the youth/family and the Case Manager/Counselor completed a review summary prior to the court hearing.

There were no exceptions to this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Youth Records. This policy was effective in July 1995 and reviewed in August 2017 by the Director of Adolescent Services.

All records are marked "confidential" and kept in a secure room or locked in a file cabinet that is marked confidential, which is accessible to program staff. Youth records are maintained in a neat and orderly manner so that staff can quickly and easily access information. All records that are transported are locked in an opaque container that is marked confidential.

All ten files reviewed were marked "confidential." All open and closed files are kept in a secure room or locked in a file cabinet that is marked "confidential" as well as behind locked doors. All files are maintained in a neat and orderly manner. Files are transported in a locked, opaque container marked "confidential."

There were no exceptions to this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The agency recently moved their residential shelter to their Tiger Bay facility. The residential shelter is now co-located with other programs run by the agency. The administration building on-site was re-modeled to accommodate the shelter. Thus, the whole residential shelter portion of the building is brand new. All youth furnishings and sleeping rooms were brand new and in excellent condition.

The SM Act Behavioral Health Center serves both CINS/FINS and DCF referral populations in the residential environment. The youth shelter provides residential services twenty-four hours a day, 365 days per year. The youth shelter operates three work shifts and is staffed with both male and female staff members on each shift. At the time of the review the shelter had seven CINS/FINS youth. The shelter has not had any Staff Secure or Domestic Minor Sex Trafficking youth since the last on-site review; however, has served Domestic Violence and Probation Respite youth.

3.01 Shelter Environment

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a policy in place for Shelter Environment. This policy was effective in July 1995 and reviewed in August 2017 by the Director of Adolescent Services.

B.E.A.C.H. House shelter shall remain in good repair and maintained to include the inside and outside of the building, grounds, and equipment. The furniture inside the shelter will be maintained in good repair, bathrooms and shower areas will be clean and functional, there will be no graffiti on walls, doors, or windows, and the grounds will be landscaped and well maintained.

The Agency has taken great care in each room to ensure there are no problems by bolting the beds to the floor and screwing the bunk beds together to ensure that they can not be separated.

All the inspections are current with the Group Care Inspection on 6/22/17, Health Inspection on 9/30/17, and the Fire Inspection on 5/18/17. The facility is new and all fixtures are in operating condition as well as all furniture is free from graffiti. All youth hygiene and personal belongings are kept in a locked closet opened by staff. The facilities daily schedule is posted through out the program and meets all contractual requirements with physical activity time, faith-based time, and reading time.

There were no exceptions to this indicator.

3.02 Program Orientation

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a policy in place for Program Orientation. This policy was effective in July 1995 and reviewed in August 2017 by the Director of Adolescent Services.

During the admission/orientation process each youth shall be provided with an orientation to the program within twenty-four hours of admission and explained its rules by a program staff. Each youth shall receive an Orientation Booklet and Client and Family Rights and Responsibilities Booklet that the youth can keep for future reference.

Five youth files were reviewed for required information and all required information was found in a neat

and orderly fashion. All youth, within the first 24 hours, of their stay were introduced to the Client handbook, Behavior Plan system, Grievance process, Emergency plans, and facility layout. All this information is signed and agreed upon by the youth and staff.

There were no exceptions in this area.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Youth Room Assignment. This policy was effective in July 1995 and reviewed in August 2017 by the Director of Adolescent Services.

A classification is used to determine upon intake the most appropriate room assignment in order to provide the safest services for the youth while in shelter. Each client at B.E.A.C.H. House is interviewed upon admission to determine the most appropriate sleeping arrangement. Staff will utilize the CINS/FINS Intake Assessment Form to assist with youth classification.

There were five youth files reviewed and all five had the CINS/FINS Intake forms inside them and that form captures all the required information of age, gender, disabilities, violence history, gang affiliation, etc. There is also a Youth Prevention Services- Safety Agreement signed by the youth and staff that states the youth will not hurt themselves or others and they if feel they want to they would talk to staff about it. All this documentation is reviewed and signed by the youth, staff working with them, and a supervisor.

There were no exceptions to this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Log Books. This policy was effective in July 1995 and reviewed in August 2017 by the Director of Adolescent Services.

The agency maintains paper log books. Log book entries must be neat, legibly written in black ink and include a brief statement providing pertinent information, names of youth and staff involved, and the name and signature of the person making the entry. Writings that could impact the safety and security of the youth are highlighted in yellow. All recording errors are struck through with a single line and initialed. White-out is prohibited. The program director or designee reviews the log book every week and makes a note chronologically in the log book. This is highlighted in pink. At the beginning of each shift, oncoming supervisor, all direct care staff, and shelter counselor reviews the log book for all shifts since their last log entry. This is highlighted in pink. Log books are to be maintained for a minimum of seven years.

The agency's logbooks are clean and free of scribbles. All entries are legible with a signature or initials at the end of each line. Shift reviews are conducted at the beginning of each shift and logbooks are reviewed, as well as, a youth count is conducted at that time. Supervisor reviews the logbook on a regular bases and that is highlighted through out the book. Camera systems are recorded and documented in the logbook. All youth movements and searches are documented. Any youth visitations and home visits are also documented in the logbook.

There were no exceptions to this indicator.

3.05 Behavior Management Strategies

Satisfactory Limited Failed

Rating Narrative

The agency has a policy in place for Behavior Management Strategies. This policy was effective in July 1995 and reviewed in August 2017 by the Director of Adolescent Services.

The youth's behavior is viewed in terms of continuous reciprocal interaction between cognitive, behavioral, and environmental influences. The Behavioral Management System is named the VIP (Very Important Person) Program which is based on the AYD logic model and is designed to provide a reward system for adaptive behaviors based on behavior modification and communication techniques. These methods are incorporated in family therapy and in educational groups in order to prepare the child and family for discharge from the program. The therapeutic practice while the child is in the program for which B.E.A.C.H. House staff shall attempt to lay a foundation for the child and family to be continued upon discharge. Staff shall impose consequences and sanctions for minor and major offenses.

The agency has a very elaborate Behavior Management Program with lots of different levels and rewards for the youth to work through. Each youth is introduced to the Behavior Management Program at intake and the staff are trained on it during their orientation training. The Program is reviewed and discussed regularly during shift reviews and monthly at staff meetings to discuss the programs effectiveness. Changes are made accordingly. There were five staff training files reviewed and all files showed that the staff received the training during their orientation training.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

Satisfactory Limited Failed

Rating Narrative

The agency has a policy in place for Staffing and Youth Supervision. This policy was effective in July 1995 and reviewed in August 2017 by the Director of Adolescent Services.

B.E.A.C.H. House will staff each shift as follows: There will be one staff member on duty for every six youth in the shelter from 7am to 11pm. There will be one staff member for each twelve youth in the shelter from 11pm to 7am. Every effort will be made to have at least two staff members on the midnight shift. The schedule is posted in the staff office for daily review. B.E.A.C.H. House will make every effort to have both male and female staff scheduled for every shift whenever the shift is housing both male and female youth.

Staff is required to maintain a count of all youth in the shelter continuously in order to know their whereabouts at all times. All youth in the shelter are accounted for on the white board and the total youth in the shelter is identified at the bottom. Staff counts every youth every fifteen minutes during sleeping hours by indicating they see them by marking off on their Special Precautions Flow Sheet.

The program meets all Florida Administrative code when it comes to staffing requirements. Four months of schedules were reviewed and all of them met requirements for at least 2 staff per shift and one staff of each gender was on all shifts except for four shifts that two females were on shift. The Agency is equipped with a camera system that, according to the Director, saves video up to 45 days. Bed checks are conducted

every 15 minutes on different times other than on the hour. Four youth charts were reviewed to witness the overnight checks on the camera system and all checks were done within the required times.

There were no exceptions to this indicator.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Special Populations. This policy was effective in July 1995 and reviewed in August 2017 by the Director of Adolescent Services.

The provider has written procedures to serve populations outside of the CINS/FINS Contract. Those populations include Domestic Violence Respite, Probation Respite, Staff Secure, and Domestic Minor Sex Trafficking.

A total of two of two Domestic Violence Respite files were reviewed. All files reviewed demonstrated that each youth had a pending DV charge and had evidence of being screen at detention, but did not meet the requirement for secure detention. Zero files exceeded the 21 day placement length of stay. All files reviewed included a case plan with goals reflecting aggression management and family coping skills.

A total of two of two Probationary Respite files were reviewed. All files reviewed demonstrated that a referral came from DJJ Probation. Zero files exceeded the 14-30 day placement length of stay. All files reviewed included a case plan with goals reflecting identified needs.

There were no exceptions to this indicator.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for the Video Surveillance System. This policy was effective in July 1995 and reviewed in August 2017 by the Director of Adolescent Services.

The agency's policy requires a twenty-four hour, seven days a week video surveillance system that can capture and store images for a minimum of thirty days. Supervisory review of the video must be conducted and documented a minimum of every fourteen days.

Agency has a new camera system that holds video for 45 days and cameras are very clear with the capability to capture pictures if necessary. Cameras are only placed in public areas and never in any bathrooms or bedrooms. There are no staff that view the cameras offsite and cameras will be able to be used during outages because they are equipped with emergency generators. The supervisor reviews cameras on random days to ensure all activities are being conducted according to this policy. The Director, her assistant, and the RSM are the only staff that can review the cameras. Currently the male side cameras are not working but a repair request has been submitted.

There were no exceptions to this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The SMA agency provides screening, counseling, and mental health assessment services. The agency has two counselors providing clinical services to the residential youth, one is a full-time Licensed Mental Health Counselor (LMHC) and the other is a part-time registered mental health intern. These two staff are overseen by a licensed Clinical Director. The shelter has staff members that are trained to screen, assess, and notify all staff members of conditions and risks of all youth admitted to both residential and non-residential CINS/FINS programs. The shelter staff provides risk screening and identification methods to detect youth referred to the program with mental health and health related risks. Specifically, the shelter utilizes a screening form to determine eligibility and various screening methods to determine the presence of risks in the youth's past mental health status, as well as their current status. The shelter also screens for the presence for acute health issues and the agency's ability to address these existing health issues. The shelter uses a general alert board and colored dot system to inform all staff members on each shift of the health and mental health status of all youth in residential youth shelter.

The shelter staff also assists in the delivery of medication to all youth admitted to the residential youth shelter. The shelter operates a detailed medication distribution system. Certain staff are designated to distribute medication. The agency uses the Pyxis Med-Station 4000 Medication Cabinet. All youth medication is stored in the Medication Cabinet. The agency provides medication distribution training to all direct care staff members, as well as, first aid response, CPR, fire safety, emergency drills and exercises, and training on suicide prevention, observation, and intervention techniques. Staff members are also required to notify parents/guardians in the event that a resident has a health injury.

4.01 Healthcare Admission Screening

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a policy in place for Healthcare Admission Screening. This policy was effective in July 1995 and reviewed in August 2017 by the Director of Adolescent Services.

The History Health Questionnaire shall be completed on all youth entering the residential program. Guardians and referral agencies shall be consulted regarding health status if available in conjunction with the youth. Staff will make every effort to complete the Health History Questionnaire within four hours of admission.

Staff will ascertain if youth is on any medication, if they are staff must obtain the name of medication, the dosage and frequency of medication, the condition the medication is prescribed for, the name of the physician who prescribed the medication, and when the last dose was taken. If the medication is to be taken while in residence, the guardian must sign the Release to Take Medication form.

Staff shall notify the Program Director is a youth is admitted with any chronic or acute health condition. The parents will be notified for any youth determined to have physical health problems through the health screening. Staff will encourage the parent or legal guardian to seek medical advice for a youth not being followed by a physician for a health issue.

The shelter uses the Physical Health Screening portion of the CINS/FINS Intake form to screen youth at admission. This is completed by the intake staff and signed by the Assistant Program Director. In addition, a Tuberculosis and Lice Screening is completed on each youth. A body chart is completed to note any scars, pain, or tattoos.

There were five youth files reviewed. All five files documented the CINS/FINS Intake form was completed at admission. None of the youth had any chronic or acute health conditions. There were three youth taking

medications and the medications as well as the reasons for them were documented. The Tuberculosis and Lice Screening, and body chart were completed in all files. The RN completes a Health History Questionnaire with each youth admitted. This was found in all five files reviewed completed within two days of admission.

There were no exceptions to this indicator.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Suicide Prevention. This policy was effective in July 1995 and reviewed in August 2017 by the Director of Adolescent Services.

The policy states the shelter will use the EIDS to screen youth at admission for suicide. In practice the shelter uses the six questions on the CINS/FINS Intake form as the initial screening for suicide. The EIDS is no longer used; however, the policy had not been updated.

The shelter uses two different levels of supervision, with the most intense level being One-to-One Supervision. This level is used for youth while waiting for removal from the shelter by law enforcement or the guardian for the purpose of Baker Act assessment. The second level of supervision used is Constant Sight and Sound Supervision. This level of supervision is for youth who are identified as being at risk of suicide but are not expressing current suicidal thoughts or threats.

The shelter has clinical staff on-site seven days a week. There are two counselors, one full-time and one part-time, who are supervised by the Clinical Director. One of the two counselors, the full-time counselor, is a Licensed Mental Health Counselor (LMHC) and the other counselor, the part-time counselor, is a registered intern. The Clinical Director is also a LMHC.

There were three youth files reviewed and all three files documented the CINS/FINS Intake Assessment form was completed during the initial intake and screening process. All CINS/FINS Intake Assessment forms were signed by a supervisor. All three files documented an assessment of suicide risk was completed by a LMHC immediately. The LMHC cleared all three youth for admission to the shelter and the intake process resumed. The youth were not placed on constant sight and sound supervision due to the LMHC completing the assessments immediately during the intake process. There was documentation in the log book each time, by the LMHC, stating the assessment was completed and the youth was cleared for intake.

Exception:

The policy states the shelter will use the EIDS to screen youth at admission for suicide. In practice the shelter uses the six questions on the CINS/FINS Intake form as the initial screening for suicide.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Medications. This policy was effective in July 1995 and reviewed in August 2017 by the Director of Adolescent Services.

There are procedures in place for storage of medication, verification of medication, steps of medication distribution, refills of medication, and disposal procedures.

The agency has two part-time Registered Nurses (RN). There is at least one RN on-site Monday thru Friday from approximately 6:30am until 2:30pm. The RN distributes all medications when on-site, trained direct care staff distribute all evening medications, as well as, distributes all medication on the weekends.

The agency provided a list of thirteen staff who are trained to supervise the self-administration of medications. There are six Super Users listed, including both RNs.

The RN train's all staff on the use of the Pyxis Med-Station and the medication administration process at hire. There is a Skills Checklist completed with the RN and newly hired staff during the training process. The checklist is signed by the staff and RN and dated when completed. All staff must complete this training with the RN before they are authorized to distribute medications. Re-trainings are completed with staff as needed.

All medication is stored in the Pyxis Med-Station, including over-the-counter (OTC) medications which are stored in drawer one of the Med-Station. Controlled medications are stored in drawer two. Prescription medications are stored in the third drawer of the Med-Station. Drawer five is used for over-sized medications, liquid medications, and topical medications. At the time of the review this drawer was empty. Medications are verified at admission using one of the four approved methods by the Florida Network. The RNs will verify the medications themselves and staff will call the pharmacy to verify the medication.

There have been twelve discrepancies in the last two weeks. Out of those twelve discrepancies, five were not closed out by the end of the staff members work day, they were all closed out the following day. All discrepancies involved inaccurate counts and were easily fixed.

Trained direct care staff complete an inventory every shift of all the controlled substances. A staff member from the outgoing shift and a staff member from the oncoming shift complete the inventory together. This inventory is documented on the youth's individual Narcotics/Controlled Substance Count Sheet and also in the logbook and highlighted in yellow. There were two youth on controlled medications at the time of the review. Both of these medications had been inventoried each shift since they entered the program. A perpetual inventory is maintained on the youth's Medication Distribution Record (MDR) each time a medication is given. Non-controlled medications are inventoried by maintaining a perpetual inventory each it is given. The RN completes a weekly inventory of all medications in the Pyxis Med-Station. This inventory was reviewed for the last six months. Inventories occurred weekly with the exception of three weeks in August 2017 and one week in September 2017.

The shelter has a system in place for refrigeration of medication if needed; however, there was no medication that required refrigeration during the time of review. A review of this refrigerator during the review revealed it was being used to store food and beverages that were not related to the medication administration process. The temperature of the refrigerator was at thirty-six degrees.

The shelter has three sharps that are inventoried weekly-- a knife-for-life, pill cutters, and scissors. There were weekly inventories for these sharps for the last six months with the exception of one week on August 2017 and three weeks in September 2017.

The shelter has four OTC's: Tums, Tylenol, Pepto-Bismol, and Allergy Relief. The Pepto-Bismol, Tums, Allergy relief were inventoried weekly for the last six months with the exception of two weeks in July 2017, all of August 2017, and three weeks in September 2017. The Tylenol was missing two weekly inventories in April, May, and July 2017, all of August 2017, and three weeks in September 2017.

The RN is currently using the Knowledge Portal as needed. Reports are reviewed on the Knowledge Portal if an incident comes up requiring it. Discrepancy reports are printed occasionally. There is not a monthly review of medication management practice via the Knowledge Portal or Pyxis Med-Station reports being conducted. The RN reported being unsure which reports to run and/or review from the Knowledge Portal.

The shelter has a process in place for refills of medications when they get low. The RN will call the youth's

parent once the medication has approximately three days remaining and request them to bring in a refill. The shelter has had to dispose of one medication since the last on-site review. Documentation of the disposal was reviewed. The medication was listed, as well as, three witnesses, and the disposal procedures. The medication was dissolved in a cup of bleach and then flushed down the toilet.

There was one youth in the shelter currently on medications. This file, as well as, two closed files were reviewed for verification of medication administration. There was documentation on the MDR that the medications were verified at admission either by the RN or by calling the pharmacy. The MDR is maintained in a binder in the medication room. All the MDRs reviewed documented the youth's name, date of birth, physician, allergies, medication the youth was taking with dosage, times to be given, common side effects, reason, and the full printed name of each staff administering medication, as well as, the youth. A picture of the youth is located in front of the MDR in the Medication Log Book. All MDRs reviewed on site document that perpetual inventories with running balances are being maintained on each medication. All MDRs reviewed for the youth also documented that all medications were given at prescribed times. Staff also document in the shelter log book when medications are given. Medications are also documented on the Shift Review form under each applicable youth.

There have been three incidents relating to medication errors in the past six months with two of those incidents happening the week prior to the on-site review. The first incident was in May 2017 and staff discovered during a review of medication that a youth did not receive medication one day. It was unable to be determined the day the youth did not receive the medication and the youth and staff both state the youth received the medication everyday. The perpetual inventory count was not correct and staff believe the error may be with counting the medication or the initial inventory of the medication.

The second incident happened the week prior to the on-site review and was due to a youth receiving two doses of a prescribed medication. It was found that the instructions written on the youth's MDR did not match the instructions on the medication bottle, resulting in staff giving the youth too much of the medication. However, after an investigation staff reported they did not give the youth two doses of the medication and although the instructions on the MDR were wrong, the instructions in the Pyxis Med-Station were right and that is what staff followed. The pill count was still inaccurate and is was unable to be determined why. Staff believe this may of happened at intake during the initial inventory of the medication or sometime during the past seven times the medication was given.

The third incident also happened the week prior to the review and was due to a youth receiving two doses of an afternoon medication. The RN had given the youth the medication before the end of her shift and then the second shift staff came on and gave the youth the medication again without looking at the MDR which documented the youth had already received the medication. The youth did not tell the staff he had already received his afternoon medication. The staff involved in this incident did receive disciplinary action and re-training.

Upon reviewing the log book another incident was found in August 2017 of an inaccurate medication count at admission. When the youth was discharged it was discovered the youth's medication was off by five pills. Upon talking to the mother and youth during discharge and reviewing the youth's MDR it was determined the count was documented wrong at admission. The MDR did confirm the youth received the medication everyday as prescribed and the youth also confirmed this. The medication was not a controlled medication so there were no shift to shift inventories completed to catch the error. In addition, this was one of the weeks previously noted in August that the RN did not do a weekly inventory of all medications resulting in the error not being caught until the medications were counted at discharge.

There is a concern with the initial counts of medication, when the youth is admitted, being accurate and also with weekly inventories of medication by the RN.

Exceptions:

There have been twelve discrepancies in the last two weeks. Out of those twelve discrepancies five were not closed out by the end of the staff members work day, they were all closed out the following day.

The RN completes a weekly inventory of all medications in the Pyxis Med-Station. This inventory was reviewed for the last six months. Inventories occurred weekly with the exception of three weeks in August

2017 and one week in September 2017.

The shelter has a system in place for refrigeration of medication if needed; however, there was no medication that required refrigeration during the time of review. A review of this refrigerator during the review revealed it was being used to store food and beverages that were not related to the medication administration process.

The shelter has three sharps are inventoried weekly, a knife-for-life, pill cutters, and scissors. There were weekly inventories for these sharps for the last six months with the exception of one week on August 2017 and three weeks in September 2017.

The shelter has four OTC's: Tums, Tylenol, Pepto-Bismol, and Allergy Relief. The Pepto-Bismol, Tums, Allergy relief were inventoried weekly for the last six months with the exception of two weeks in July 2017, all of August 2017, and three weeks in September 2017. The Tylenol was missing two weekly inventories in April, May, and July 2017, all of August 2017, and three weeks in September 2017.

The RN is currently using the Knowledge Portal as needed. Reports are reviewed on the Knowledge Portal if an incident comes up requiring it. Discrepancy reports are printed occasionally. There is not a monthly review of medication management practice via the Knowledge Portal or Pyxis Med-Station reports being conducted. The RN reported being unsure which reports to run and/or review from the Knowledge Portal.

There have been three CCC reports in the last six months relating to medication errors, with two of those incidents occurring the week prior to the on-site review. In addition there was another incident in August 2017 of inaccurate med count at admission.

Seems to be an issue with initial counts of meds and also weekly inventories by the RN.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for the Medical/Mental Health Alert Process. This policy was effective in July 1995 and reviewed in August 2017 by the Director of Adolescent Services.

The agency has a written procedure to address the medical and mental health alert process for all youth admitted to the youth shelter. The shelter utilizes a large dry erase board located in the Youth Specialists' work area. The shelter uses a color-coded alert system with each color identifying a different alert. The applicable color-coded dots are placed next to the youth's name on the alert board. The colors used are: dark green for a suicide history; dark blue for mental health; orange for substance abuse; yellow with black dot for runaway behaviors; red for medical and allergies; pink for sexual issues; yellow for out of shelter; and brown for no outings. All alerts and allergies are also documented on the Shift Review form that is completed each shift and reviewed at each shift change.

A SANS note is completed on each youth after admission that will document all alerts, allergies, and medical conditions that were identified during the admission process. This note is placed in the youth's file. The "Alert" sticker on the front of the youth's file is checked "yes" if there were alerts identified during admission and "no" if not. An orange "allergies" sticker is placed on the front of the youth's file, if any allergies are identified, and the allergy is documented on the sticker. All food related allergies are also documented on a form located in the kitchen.

A review of five open youth files was conducted. All applicable alerts were documented in the youth's file. All files also had a sticker on the front of the file checked "yes" for alerts if applicable. If the youth had any allergies then they were also documented on the front of the file. Alerts were also documented on the Shift Review Forms. These forms were reviewed to indicate staff were provided sufficient information and instructions regarding the youth's medical conditions, allergies, and information to allow them to recognize and respond to the need for emergency care and treatment. All alerts were also appropriately

documented on the large dry erase board in the Youth Specialists' work area. There were no dietary alerts or food allergies at the time of the review.

There were no exceptions to this indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Episodic/Emergency Care. This policy was effective in July 1995 and reviewed in August 2017 by the Director of Adolescent Services.

All direct care staff are required to have current CPR and First Aid Certification. A "knife for life" and wire cutter will be mounted on a board inside the medication room. First aid kits are located in the staff work area, in the medication room, and in each vehicle. The first aid supplies will be examined every month for replacement supplies, potency of sterile items, and expiration dates. Basic first aid must be logged on the episodic/emergency care log in the staff office. Medical drills will be conducted monthly on various shifts to prepare staff for emergency situations. Emergency situations are reviewed monthly at staff meetings in order to keep all staff informed of incidents.

If a youth needs emergency medical attention staff will call the Program Director or designee to staff and make a determination on means by which youth shall be transported for emergency care. Staff will then call the legal guardian, Program Director, and on call supervisor for notification. Upon discharge from the hospital should youth return directly to the shelter, the legal guardian must provide discharge instructions and any prescribed medications.

There have been three instances of youth being provided first aid care on-site and one instance of a youth being transported off-site to the hospital for emergency medical care, since the last on-site review. All four instances were logged on the Episodic Care Log. The three instances of youth being provided first aid care on-site were due to injuries occurred during outside recreation time, two youth had a bloody nose and one youth jammed fingers. An occurrence report was completed on three of these incidents and the supervisor and youth's parent were also notified. The one case of the youth being transported off-site, the youth was having chest pains. EMS was notified and transported the youth to the hospital. The youth's parent was notified, as well as, the Program Director. An occurrence report was completed. All four incidents were also documented in the program log book.

The shelter has adequate first aid kits, a knife for life, and a pair of wire cutters. First aid kits are located in the medication room, in the staff work area, and in each vehicle. The RN reviews the first aid kits and stocks them; however, there is not a formal process in place for this and no documentation of it. The first aid kits were reviewed and were found to be fully stocked with no expired items. The shelter conducts three medical emergency drills each month, one on each shift. The drills cover an array of emergency medical situations.

Exception:

The RN reviews the first aid kits and stocks them; however, there is not a formal process in place for this and no documentation of it. The first aid kits were reviewed and were found to be fully stocked with no expired items.