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

Review of CDS-Interface Central

on 01/16/2019

# 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 | Limited |
| 1.05 Analyzing and Reporting Information | Satisfactory |
| 1.06 Client Transportation | Satisfactory |
| 1.07 Outreach Services | Satisfactory |

Percent of indicators rated Satisfactory:85.71%
Percent of indicators rated Limited:14.29%
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/Petitiion Process | Satisfactory |
| 2.07 Youth Records | Satisfactory |
| 2.08 Sexual Orientation, Gender Identity/Expression | 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 4: Mental Health/Health Services** | |
|---|---|
| 4.01 Healthcare Admission Screening | Satisfactory |
| 4.02 Suicide Prevention | Satisfactory |
| 4.03 Medications | Satisfactory |
| 4.04 Medical/Mental Health Alert Process | Satisfactory |
| 4.05 Episodic/Emergency Care | Satisfactory |

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

Percent of indicators rated Satisfactory:96.43%
Percent of indicators rated Limited:3.57%
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/Consultant, Forefront LLC

Katina Horner, Regional Monitor, Department of Juvenile Justice

Kim Stone, Operations Supervisor, SMA Beach House

Janet Valdez, CINS/FINS Program Supervisor, Children's Home Society

Shawn Block, CINS/FINS Shelter Program Administrator, Anchorage

## Persons Interviewed

- [ ] Chief Executive Officer
- [ ] Executive Director
- [x] Chief Operating Officer
- [ ] Chief Financial Officer
- [x] Program Director
- [x] Program Manager
- [ ] Program Coordinator
- [x] Direct- Care Full time
- [ ] Direct-Care Part Time
- [ ] Direct-Care On- Call
- [ ] Volunteer
- [ ] Intern
- [x] Clinical Director
- [x] Counselor Licensed
- [x] Counselor Non- Licensed
- [x] Case Manager
- [ ] Advocate
- [x] Human Resources
- [x] Nurse

2 Case Managers
1 Program Supervisors
1 Health Care Staff

0 Maintenance Personnel
0 Food Service Personnel

3 Clinical Staff
0 Other

## Documents Reviewed

- [ ] Accreditation Reports
- [x] Affidavit of Good Moral Character
- [x] CCC Reports
- [x] Logbooks
- [ ] Continuity of Operation Plan
- [ ] Contract Monitoring Reports
- [ ] Contract Scope of Services
- [x] Egress Plans
- [x] Fire Inspection Report
- [ ] Exposure Control Plan
- [x] Fire Prevention Plan
- [x] Grievance Process/Records
- [ ] Key Control Log
- [x] Fire Drill Log
- [x] Medical and Mental Health Alerts
- [x] Table of Organization
- [x] Precautionary Observation Logs
- [x] Program Schedules
- [ ] Telephone Logs
- [ ] Supplemental Contracts
- [x] Vehicle Inspection Reports
- [ ] Visitation Logs
- [x] Youth Handbook

5 # Health Records
2 # MH/SA Records
3 # Personnel Records
6 # Training Records
5 # Youth Records (Closed)
5 # Youth Records (Open)
0 # Other

## Surveys

3 Youth  5 Direct Care Staff

## Observations During Review

- [ ] Intake
- [x] Program Activities
- [ ] Recreation
- [ ] Searches
- [x] Security Video Tapes
- [x] Social Skill Modeling by Staff
- [ ] Medication Administration
- [x] Posting of Abuse Hotline
- [ ] Tool Inventory and Storage
- [x] Toxic Item Inventory and Storage
- [ ] Discharge
- [ ] Treatment Team Meetings
- [ ] Youth Movement and Counts
- [x] Staff Interactions with Youth
- [x] Staff Supervision of Youth
- [x] Facility and Grounds
- [x] First Aid Kit(s)
- [ ] Group
- [ ] Meals

## Comments

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

## Strengths and Innovative Approaches

Rating Narrative

The agency started a project called the Strong Roots Movement. This is a project coordinator with a group of students from the University of Florida, that brings organic edible garden beds to schools and programs, to help teach the upcoming generation how to be green, organic, and sustainable. These garden beds are a way of teaching important environmental solutions and showing the youth how to love and nurture something to life, therefore benefiting their overall mental health. All the materials needed to build and maintain the garden were donated. The UF group helped the youth build the beds, plant the vegetables and herbs, and make return visits to help care for the beds. The garden beds have produced vegetables that have been harvested and consumed.

The program hired a new House Manager. He was the House Manager a few years ago and retired so he is familiar with the program and position.

The Interface-Central team had three days of a Retreat/Training during the summer of 2018. Some areas of focus were team building, medication procedures, trauma sensitive approach, and policy reviews.

The fire alarm system in the shelter had to be completely replaced. The whole process took about eight weeks. During that time they were directed by the fire department to convert doing a "fire watch" process verses the drill process. Staff completed manual hourly checks of every room in the facility to ensure no visible signs of fire or hazard were occurring.

The program has started the process to move to an Electronic Log Book.

Challenge Grant money will make it possible to replace the stove in the kitchen and change the flooring in the youth living areas.

The shelters video surveillance system has had some intermittent times of not recording due to system interruptions. These issues are related to the phone/internet capabilities. They are working with IT staff to keep them operating at an effective level.

# Standard 1: Management Accountability

## Overview

Narrative

The daily operations of CDS Central Residential and Non-Residential programs are overseen by a Regional Coordinator. The Regional Coordinator position is the highest ranking position for the agency at this location. The agency also has Residential and Non-Residential counselors, Residential Direct Care and Non-Residential staff members. The agency has a Centralized Human Resources and fiscal departments that are responsible for all personnel and financial matters respectively. All CDS Residential Shelters and Non-Residential Programs have implemented uniform operating protocols for all three service locations in their respective service areas. Other uniform program and operations protocol for all three locations include training and professional development exercises.

The agency conducts background screenings prior to the hiring of all staff members. All staff members receive on the job training at their respective service locations. In addition, many agency trainings are consolidated to reduce costs and ensure that all staff members receive standardized training. The agency conducts outreach throughout their designated service regions to local youth, parents/guardians, local community organizations, partners, and stakeholders.

The agency utilizes various data collection methods. Designated agency leadership teams develop monthly and quarterly reports that focus on accountability, risk management, contract deliverables, programming and operations. Reports are analyzed by specific staff and specific strategies are developed to address identified issues and goals accordingly.

## 1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy in place titled Background Screening. The policy manual was last updated January 4, 2019 by the Chief Operations Officer.

Background screenings will be processed and housed in the Care Provider Background Screening Clearinghouse online portal. Screening results will be displayed on the Clearinghouse website within three to seven days from when DJJ BSU receives the packet and fingerprint data. No offer of employment or volunteer/internship may be made prior to receipt of DJJ clearance. Five-year re-screens should be conducted on employees, calculated from the “Retained Prints Expiration Date” posted on the Clearinghouse site.

Since the last annual review, the program hired seven new staff and thirty-one volunteers. All background screenings were reviewed using the Clearinghouse and volunteer files. Local criminal checks were completed and reviewed for each applicant. Each applicant signed a Criminal History Acknowledgement and Prison Rape Elimination Act (PREA) Compliance Form.

All seven background screenings were completed prior to staff hires. Twenty-one active background screenings were completed prior to volunteer start dates. The remaining ten completed orientation, but never returned to volunteer.

Three staff required five-year re-screens and they were completed as required.

The program began using Predictive Index, which is an online pre-assessment tool. All new staff were hired prior to the implementation of the pre-assessment tool.

The Annual Affidavit of Compliance with Good and Moral Character was submitted to the Department on January 7, 2019 and signed by the Chief Operations Officer.

There were no exceptions to this indicator.

## 1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy in place titled Provision of an Abuse Free Environment. The policy manual was last updated January 4, 2019 by the Chief Operations Officer.

The agency’s procedures require the program to provide an environment in which youth and staff feel safe, secure, and not threatened by any form of abuse or harassment. All staff are responsible for reporting abuse, abandonment, or neglect of a child. Each youth has a right to grieve and their complaint will be heard within 72 hours on each level.

Three staff training files were reviewed. As a part of orientation staff agree to adhere to the code of conduct, which prohibits the use of physical abuse, profanity, threats, or intimidation. The program's code of conduct require staff to not deprive youth of basic needs, such as food, clothing, shelter, medical care, and security. Three orientation plans were reviewed and signed by staff in all three cases. All three staff sampled had documentation of child abuse reporting procedures.

Information for contacting the Florida Abuse Hotline is posted throughout the program. There has not been any Central Communication Center (CCC) or internal incident reports of abuse or staff discipline related to youth during the past six months.

The program has a locked grievance box in the common area for youth to access. The program had one grievance since the last review, dated October 10, 2018. The youth's grievance was addressed by a Residential Counselor on October 11, 2018 with a resolution the youth was satisfied with.

There were three youth surveyed. All three youth reported they knew the Abuse Hotline was available for them to call if they wanted, but all three stated they have never needed to make a call. All three youth stated staff treat them professionally and they have never heard staff use threats or intimidation on them or any other youth. All three youth felt safe in the shelter.

There were five staff surveyed. All five staff reported they have been trained on abuse reporting and both reported they were aware they needed to report any suspected abuse to the Abuse Hotline. All five staff reported they have never heard a staff deny a youth access to the abuse hotline. All five staff reported they have never heard another staff use inappropriate language in front of the youth.

There were no exceptions to this indicator.

## 1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy in place titled Incident Reporting. The policy manual was last updated January 4, 2019 by the Chief Operations Officer.

The program’s procedures require the program to record all incidents to better understand and analyze how to improve safety and services. Reports are required to be legible and thoroughly written. All documented incidents will be sent to the Chief Operations Officer. All reportable incidents must be called into the CCC within two hours of the event and the supervisor on duty must be notified.

Ten Internal and twelve CCC incident reports during the past six months were reviewed. The Chief Operations Officer (COO) and management were notified and reviewed all documented incident reports. The program notified the Department’s CCC within two hours in eleven of twelve cases. The program completed follow-up communication as required by the CCC. A separate binder for all internal and CCC incidents is maintained for all documented incidents. All incidents were documented on an incident reporting form. The DJJ CCC hotline number is posted throughout the program.

There were no exceptions to this indicator.

## 1.04 Training Requirements

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The program has a written policy in place titled Training Requirements. The policy manual was last updated January 4, 2019 by the Chief Operations Officer.

The program’s procedures require the Chief Operations Officer to act as the program’s Training Director and work with the appropriate level supervisor who manages their staff training budget to address training issues. All training shall be properly recorded on forms designed for that purpose. The Regional Coordinator will assess training plans annually and develop a quarterly training calendar.

Three staff training files and SkillPro were reviewed for first year training requirements. All three staff met or exceeded the total number of hours with 182, 156, and 146.5 individual training hours during their first year of employment.

During the first 120 days all required training topics were documented in one of three cases. The two remaining staff were missing between one and three required trainings.

Documentation for all required training topics after 120 days of employment was not in the training files or in SkillPro for all three staff. Each of the three staff were missing between five and ten required trainings.

There were three staff training files reviewed for annual training requirements. The staff documented 39, 37.5, and 29.5 hours of the required 40 hours of training for the last completed training cycle of fiscal year 2017-2018. All three staff were missing required trainings. One staff was missing Suicide Prevention Part 2, Fire Safety Equipment, and Human Trafficking 101 training. Another staff was missing Suicide Prevention Part 1 and 2, Prison Rape Elimination Act (PREA), Sexual Harassment, and Human Trafficking 101. The third staff was missing Suicide Prevention Part 2, Fire Safety Equipment, and Human Trafficking 101.

Two training files reviewed for first year training requirements were missing between one and three trainings required during the first 120 days of employment. All thee training files reviewed for first year training requirements were missing between five and ten additional trainings required during the first year of employment.

None of the three training files reviewed for annual training requirements documented the full forty hours of required annual training. In addition, all three staff were missing multiple required trainings.

## 1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy in place titled Analyzing and Reporting Information. The policy manual was last updated January 4, 2019 by the Chief Operations Officer.

The program's procedures require the program to collect and review several sources of information to identify patterns and trends including quarterly case review reports, incidents, accidents, and grievances. An annual review is required for customer satisfaction data, outcome data, and monthly review of NetMIS data reports. Findings will be reviewed by management and communicated to staff and stakeholders.

The annual CDS performance and risk management report from the past fiscal year was reviewed. The report included performance analysis data from participant satisfaction surveys, demographics of all participants, performance and projections, monthly shelter utilization, outreach, risk, and issue distribution. Other areas addressed included annual data collection of screenings, admissions, discharges, emergency shelter participants, NetMIS data entry, medical emergencies, incident summary report, and personnel summaries.

A performance improvement and risk management report are developed every fiscal year. The data is captured using graphs, charts, spreadsheets, and in written forms. This information is also captured and analyzed monthly. Monthly data is collected for participant performance based on contracted deliverables, incidents, accidents, and grievances.

The program conducts quarterly participant, peer, and supervisor reviews on two open and two closed files.

All data collection is shared and reviewed with management and staff monthly as documented in meeting minutes and agendas reviewed for the past six months. Any improvements or corrective actions needed are implemented at this time.

There were no exceptions to this indicator.

## 1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy to address Client Transportation titled Vehicles Use and Safety Inspection. The policy was last reviewed on January 4, 2019 by the Chief Operations Officer.

The policy states the best practice to help prevent any situations of alleged impropriety is to always have a third party present who could be another staff, intern, volunteer or resident. There is a provision within the policy that if a third party cannot be obtained that the program supervisor is aware of the situation prior to the transport and is documented approval based on participant's history behavior, prior transports, staff's work performance and history shows no inappropriate behavior. The agency has a form called Transportation Exceptions Approval Log (Single/Third Party) which is completed by the approving Supervisor. Whenever there is a client transportation there is documentation regarding names of all the persons in the vehicle, date and time, the purpose/destination. The agency has a form call Travel Log/Van which all the required information listed.

The agency uses a form called Single/Third Party Transportation Exceptions Approval which is used by the Supervisor to approve single client transports. This is a blanket form which lists all the youth in the shelter, as well as all the staff and is completed for seven days at a time. According to the Supervisor, during Clinical Staffing on Wednesdays the group discuss who is appropriate for single transports this is then reflected on the form. The program also uses a transportation log called Travel Log/Van CINS/FINS; this form has the date, name of the client(s) being transported, the number of clients being transported, where the client(s) is be transported to/from, the start time and mileage, end time and mileage, and the driver and second adult if present. The program also documents transportation's in the Program Log Book. A random check of single client transports were reviewed for the following dates; 8/28/2018, 9/6/2018, 10/24/2018, 11/29/2018, and 12/20/2018. Each single transport which was listed on the Travel Log/Van was cross referenced with the Single/Third Party Transportation Exceptions Approval for the corresponding dates. In all the cases reviewed the youth and staff completing the single transport were approved.

There were no exceptions to this indicator.

## 1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled Outreach Services. The policy was last reviewed January 4, 2019 by the Chief Operations Officer.

The Prevention Outreach program reflects the commitment of all staff to provide services designed to increase the public awareness of the needs of troubled youth at risk of running away, being habitually truant or being beyond the control of their parents or guardian. CDS staff do this by participating in local DJJ Board and Council Meetings to ensure CINS/FINS services are represented. Community Outreach staff are available for support as well as providing materials and maintaining and updating the CDS website and Facebook. The Regional Coordinator is responsible for coordinating prevention services and training staff on documenting. The Prevention Outreach Program provides Early Intervention Services, which is focused on schools, family, individuals, and peers; Informational Services, Educational Services, Alternative Services and Community Development Services. It is the responsibility of the Outreach Program to coordinate with local agencies and coordinate with schools.

Based on the information reviewed the agency has a strong outreach program. There is documentation showing the agency had multiple staff representation, most of the time, at the last four Alachua County Juvenile Justice Council meetings for 9/7/2018, 10/5/2018, 11/9/2018, and 12/7/2018; there was no meeting for August 2018.

The agency has a position called Community Outreach Specialist who is responsible for agency outreach and Safe Place. The Community Outreach Specialist provided a 2018 Outreach Actives log/flyer for the last six months with a list of monthly activities, as well as pictures. Based on the log, multiple outreach activities were conducted monthly showing a very active outreach program which included attending the United Way Agency Fair in August, the Children's Regional Advisory Board Meeting in October, and the Human Trafficking Board Meeting in December. The agency also sends out a monthly newsletter to the community and other agency partners informing them of activities and

services.

The agency has a list of forty-six Cooperative Service Agreements; there was also a binder with the signed agreements for review.

There were no exceptions to this indicator.

# Standard 2: Intervention and Case Management

## Overview

Rating Narrative

The Non-Residential Counseling Program provides services for youth and their families primarily in Alachua, Gilchrest, and Levy Counties. The program receives calls for services from parents, guardians, system partners, and the general community. The non-residential component for CDS Central consists of four Non-Residential Counselors; three of which are Master's level Counselors and one holds a Ph.D, and one Medical Records Technician. All Family Action Staff members and residential counseling staff members have access to the agency's Non-Residential Regional Coordinator, who is a Licensed Mental Health Counselor (LMHC).

The screening determines eligible youth and family whom are referred to the respective residential or nonresidential program to start the intake process. If the program is full at the time of referral, the agency will make a referral for the family to another appropriate community agency, according to the youth's zip code.

The program has the capability to offer both case management and substance abuse prevention education on an as needed basis. The agency conducts Case Staffings, which are statutorily-mandated committees that develop formalized treatment plans for status offenders when all other services have been exhausted. If needed, the Case Staffing Committee can also recommend the filing of a CINS Petition with the court.

Both the Residential Supervisor and residential and non-residential CDS Central counseling staff are engaged in partnerships with local school systems regarding the options available for status offenders and the overall petitions process and displayed a high level of knowledge and insight regarding their involvement in the community in this area.

## 2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has three different polices to address the requirements of this indicator. The policies titled Intake/Assessment, Screening for Eligibility and Target Population, and 24-Hour Telephone Access were all last reviewed on January 4, 2019 by the Chief Operations Officer.

The provider's procedure requires the trained staff to complete the intake screening process upon receiving the referral within 24 hours, but no later than seven calendar days. The provider's procedures also state that upon completion of the intake screening, the intake/assessment process needs to be initiated within seven days along with necessary assessments.

There were five Residential files (three open and two closed) and five Non-Residential files (three open and two closed) reviewed.

All ten files documented the eligibility screening was completed within seven calendar days of referral. All ten files indicated that the youth and parents/guardians received the following in writing from provider: available service options, rights and responsibilities of youth and parents/guardians and, a parent/guardian brochure. All files indicated that the youth and parents/guardians have access to possible actions occurring through involvement with CINS/FINS services and grievance procedures.

Thee were no exceptions to this indicator.

## 2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled Needs Assessment that addresses the requirements of the indicator. The policy was last reviewed January 4, 2019 by the Chief Operations Officer.

The provider's procedure requires a Bachelor's or Master's level staff member to initiate or attempt the Needs Assessment within 72 hours of admission. The Needs Assessment is to be completed within two to three face-to-face contacts following the initial intake. The provider requires the counselor/case manager to sign and date the Needs Assessment form corresponding to the date of completion. The supervisor is then required to review and sign the completed document. If suicide risk component is required it must be reviewed by a licensed clinical supervisor or written by licensed clinical staff.

There were five Residential (three open and two closed) and five Non-Residential (three open and two closed) reviewed.

In all five Residential files, the Needs Assessment was initiated within 72 hours of admission. All ten files documented 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. All ten Needs Assessments included a supervisor review signature upon completion.

There were two files that indicated the youth had an elevated risk of suicide as a result of the Needs Assessment. These files had a completed Assessment of Suicide Risk which was conducted by a licensed mental health professional.

There were no exceptions to this indicator.

## 2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled Individual Plan that addresses the requirements of the indicator.. The policy was last reviewed January 4, 2019 by the Chief Operations Officer.

The provider's procedure requires an Individual Plan to be developed with the youth and family within seven working days, following completion of the assessment. The provider outlines all the requirements for each Individual Plan that needs to be included, which corresponds to the requirements outlined in the indicator. The Case/Service Plan includes the following: individualized and prioritized need(s) and goal(s) identified by the Needs Assessment, service type, frequency, location, person(s) responsible, target date(s) for completion, actual completion date(s), signature of youth, parent/guardian, counselor and supervisor, date the plan was initiated, and reviewed for progress/revised by counselor and parent (if available) every thirty days for the first three months and every six months after.

There were five Residential files (three open and two closed) and five Non-Residential files (three open and two closed) reviewed.

All ten files had the Case/Service Plan developed within seven working days of Needs Assessment. All ten Plans documented individualized and prioritized need(s) and goal(s) identified by the Needs Assessment, the service type, frequency, and location for services, the person(s) responsible, the target date(s) for completion, and the date the plan was initiated. Actual completion dates were documented in the four closed files. All ten files had youth, parent/guardian, counselor, and supervisor signatures.

The Case/Service Plans were reviewed for progress/revised by the counselor and parent every thirty days for the first three months and every six months after if applicable.

There were no exceptions to this indicator.

## 2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled Case Management, Counseling, and Service Delivery. The policy was last reviewed on January 4, 2019 by the Chief Operations Officer.

The provider's procedure requires the assigned counselor/case manager/residential counselor to be responsible for providing the individual and family counseling based on the Individual Plan. The counselor/case managers are responsible for following the youth's case and to ensure youth/family receive the necessary services and/or referrals needed based on their Individual Plan. The process includes the following: establish referral needs and coordinate referrals based on the ongoing assessment of the youth/family problems and needs identified in the Individual Plan, coordinate Individual Plan implementations, monitoring youth's/family's progress in services and providing support for the families, monitoring out-of-home placement, if necessary, making referrals to the case staffing committee, as needed to address the problems and needs of the youth/family, recommending and pursuing judicial intervention in cases as appropriate, accompanying youth and parent/guardian to court hearings and related appointments (if applicable), make referrals to additional services, if needed, continued case monitoring and review of court orders and case termination with a follow-up.

There were five Residential files (three open and two closed) and five Non-Residential files (three open and two closed) reviewed.

All ten 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 Non-Residential files were not applicable for monitoring out-of-home placement.

All ten files referred the youth/family for additional services when appropriate and provided case monitoring and review of court orders.

Referrals to Case Staffing were made if needed, and the Counselor/Case Manager accompanied the family to court and other meetings when needed. These efforts were noted in emails, progress notes, and meeting summaries.

All four closed files provided case termination notes. All four closed files also documented thirty day follow-ups were completed as required. None of the files were due for a sixty day follow-up.

There were no exceptions to this indicator.

## 2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled Case Management, Counseling, and Service Delivery. The policy was last reviewed on January 4, 2019 by the Chief Operations Officer.

The agency procedure requires counselor/case managers to be responsible for documenting all contacts in progress notes and maintaining them in the participant's file which includes regular contact with the youth and family as well as any outside service providers that may be applicable. Counselor/case manager is to ensure continuity of care along with monitor delivery of services.

Residential counselors are to give individual counseling based on the Individual Plan, group counseling sessions based on established group process procedures; which are to be conducted a minimum of five days per week focusing on clear and relevant topics (informational/developmental/educational). Group sessions are to have a clear leader or facilitator and be at least thirty minutes in length. Group sessions should be an opportunity for youth to engage. Non-residential counselors provide services through a therapeutic community based service designed to provide the intervention necessary to: stabilize the family in the event of a crisis, keep families intact, minimize out-of-home placement, provide aftercare services for youth returning home from shelter services and prevent the involvement of families in the delinquency and dependency systems.

There were five Residential files (three open and two closed) and five Non-Residential files (three open and two closed) reviewed.

All ten files had youth's presenting problems addressed in the Needs Assessment, in the initial Case/Service Plan, and in the Case/Service Plan reviews. Case notes were maintained for all counseling services provided and documented the youth's progress.

All ten files had an on-going internal process that ensures clinical reviews of case records and staff performance. All ten files documented the youth and families received counseling services in accordance with the Case/Service Plan and that individual/family counseling was provided.

All five Residential files indicated that group counseling sessions were provided at least five days a week, if not more. The counseling sessions documented of the following: at least thirty minutes in length, clear leader or facilitator, clear and relevant topic

(informational/developmental/educational), and opportunity for youth engagement.

There were no exceptions to this indicator.

## 2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has three different policies in place to address this indicator, Case Staffing Committee: Plan of Services, Case Staffing Committee: Review and Committee Composition, and Case Staffing Committee: Parent/Guardian Request. The policies were reviewed on January 4, 2019 by the Chief Operations Officer.

The agency's procedure states that a Case Staffing Committee meeting is to be held to review cases determined in need of services or treatment if: the family or youth is not in agreement with the services or treatment offered, the family or youth will not participate in the services or treatment selected, the counselor/case manager needs assistance in developing an appropriate Individual Plan, the parent or guardian, or any member of the committee requests that a Case Staffing Committee meeting be arranged (If requested by a parent, a Case Staffing Committee meeting must be held within seven days, excluding weekends and holidays, of written request). The counselor/case manager is responsible for implementing and monitoring the Plan of Services. A copy is required to be sent to the parent/guardian within seven days of the meeting to provide a written report outlining reasons for or against a petition being filed and the recommendations. The Case Staffing Committee must include, but not limited to, the following: a representative from the Department of Juvenile Justice or designee in accordance with the CINS/FINS Operations Manual, a representative of the CINS/FINS provider and a representative of the youth's school district.

There were two case staffing files reviewed. In one file, the parent requested the staffing and it was held within seven days.

Both files indicated the family was notified of the staffing no less than five working days prior to the staffing and indicated a local school district representative was present at staffing, as well as a DJJ representative and/or CINS/FINS provider.

Both files documented that the attendance officer also attended the staffing, as well as a mental health representative.

There was documentation in both files that the youth and family were provided a new or revised plan for services and a written report was provided to the parent/guardian within seven days of the case staffing meeting, outlining recommendations and reasons behind the recommendations.

Both files documented the program worked with the circuit court for judicial intervention for the youth and family and the Case Manager/Counselor completed a review summary prior to the court hearing.

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 as well as notifying committee members when no case staffing will be held.

There were no exceptions to this indicator.

## 2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place titled Youth Case Records that addresses the requirements of the indicator. The policy was last reviewed on January 4, 2019 by the Chief Operations Officer.

The provider's procedure requires that an official record shall be maintained for each youth receiving services upon Intake. Case records are to be kept in a neat, orderly manner. All records are to be marked as "confidential" and stored in a secure room or locked in a file cabinet that is marked "confidential." When in transport, all records are to be locked in an opaque container marked "confidential."

There were five Residential files (three open and two closed) and five Non-Residential files (three open and two closed) reviewed.

Each youth had an official case record. All files were labeled confidential and maintained in a neat and orderly manner. All files at the

Residential program were observed to be kept in the staff office, in a locked file cabinet that was marked "confidential". The program uses a locked, opaque suitcase to transport records.

There were no exceptions to this indicator.

## 2.08 Sexual Orientation, Gender Identity/Expression

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled Sexual Orientation, Gender Identity, Gender Expression that addresses the requirements of the indicator. The policy was last reviewed on January 4, 2019 by the Chief Operations Officer.

Youth are addressed according to their preferred name and gender pronouns. Youth's preferred name and gender pronouns are used in the logbook and on all outward facing documents and census boards. All staff, service providers, and volunteers have knowledge of the Florida Network CINS/FINS Policy #5.08 and the terms defined therein. Youth in need of specialized support are referred to qualified resources. Youth is not roomed in isolation due to sexual orientation, gender identity, or gender expression.

The shelter has the SOGIE policy posted in the visitor lobby area of the facility for all visitors to read and review. All staff were trained on the SOGIE policy in August 2018. The agency also completed a Gender Preference training for all staff on January 10, 2019. It was reported that volunteers and interns are trained on the SOGIE policy during their orientation training; however, there was no documentation of this training as it is not listed on the orientation training checklist. At admission, the counselor reviews the information in the SOGIE policy with the youth and asks the youth their preferred gender pronoun to be used. This is all documented on the last page of the Intake Assessment form by the counselor.

The shelter has signage located throughout the shelter indicating the program is a safe space for all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression. Signage is located in the computer lab, both male and female dorms, staff office, and a bulletin board was created in the hallway with various SOGIE postings. There is a posting next to the youth alert board in the staff office for staff to review reminding them of proper documentation and use of gender pronouns for all youth.

There was no documentation volunteers and interns receive training on the SOGIE policy.

# Standard 3: Shelter Care

## Overview

Rating Narrative

The CDS Central youth shelter is located in Gainesville, Florida in Alachua County. The CDS Central facility operates twenty-four hours per day, seven days per week and is licensed by the Department of Children and families for twenty beds. The agency serves both CINS/FINS and DCF program participants.

The shelter is comprised of a detached building that is a one level landscape or ranch style design. The shelter has both a front and side entrance. The building is designed with equally sized dorms and day rooms for female and male residential clients. Each residential section of the shelter can accommodate up to ten to twelve residents. The female and male sides of the facility are equipped with a large dorm, bathrooms, and a dayroom. The facility includes a kitchen and dining area, Youth Care Work station, staff offices, a smaller meeting room, multipurpose recreation, and an instruction/class room. Youth that are not in school spend a majority of their free time in the dayroom either engaged in planned life skills activities, playing video games, watching television, or completing homework assignments on the computers. Youth attend local area schools if they are not on suspension, expulsion, or suffering from an illness.

The exterior of the facility is well-maintained and the grounds are landscaped. The facility site has limited green space, but does have an open court in the rear of the facility. The rear area of the facility is enclosed by private wood fencing.

The program staff for the Residential staff includes a Regional Coordinator; a Residential Supervisor; a Life Skills Educator, a House Manager, a Cook, one Senior Youth Care Worker; twenty-five full-time, part-time and PRN Youth Care Workers; one administrative staff person; and one Registered Nurse. Two Residential Counselors are assigned to provide counseling and case management services to the residential program. The Youth Care Workers are primarily responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision, and general assistance.

## 3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled Shelter Environment to address the requirements of this indicator. The policy was reviewed and signed on January 4, 2019 by the Chief Operations Officer.

The policy outlines the fire plan, education and leisure activities, as well as the opportunity to participate in faith based activities. Youth as well as their parents are provided with an orientation packet outlining the expectations for providing a safe, neat, clean environment as well as providing information on daily structured programming.

A copy of the current DCF Child Care License was provided for review as well as being displayed in shelter.

A tour of the facility was provided and was found to be in good repair. The program was free of insect infestation and the grounds were landscaped and well maintained.

Upon inspection, both male and female living/sleep areas were tidy and the bathrooms were clean, functional, and free of graffiti.

Staff provided access to two company vans, which were both found to be locked and secure. Each van was equipped with all required safety equipment. In addition four staff vehicles were also found to be locked.

A review of the last fire inspection indicates that the program is in compliance with the local Fire Marshall. Fire drills were completed regularly with the exception of August and September at which time it was reported the program experienced issues with their alarm system. The program did provide a daily Fire Watch Log that indicated a Safety Walk was completed regularly in compliance with request of the Fire Marshall through September 28, 2018 when the alarm was restored. Documentation was provided that staff complete one mock emergency drill per shift each quarter.

A youth schedule was provided and reviewed, which indicated education, recreation, counseling services, and life/social skills activities were offered during their stay. The youth schedule was found to be posted in multiple areas throughout the facility. A review of three open youth files and the logbook indicated youth participation in these activities.

There were no exceptions to this indicator.

## 3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CDS Central has a policy and procedure in place outlining the admission/intake process and participant orientation that is provided within the first twenty-four hours of intake. This policy was reviewed and signed on January 4, 2019 by the Chief Operations Officer.

At intake, staff provide each youth with a detailed program orientation informing the youth (but not limited to) of the following:

Identifying key staff and their roles

Review of emergency evacuation procedures

Program tour/physical layout of the facility

Program dress code

List of  prohibited contraband

Grievance process

Daily schedule

Review the program rules

Access to medical and mental health procedures

There were five youth files reviewed (three open and two closed).

All five files documented the youth received a comprehensive orientation and were provided a handbook within the first twenty-four hours of admission. The orientation included a review of disciplinary actions, explanation of the grievance procedure, a review of emergency procedures, and contraband rules. Youth were given a tour of the facility and assigned a bed. The daily activity schedule and abuse hotline number were provided to the youth and parent. The youth and parent both signed the orientation checklist in all five files.

There were no exceptions to this indicator.

## 3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure in place outlining room assignments which is titled "Sleeping Arrangements". This Policy was reviewed and signed on January 4, 2019 by the Chief Operations Officer.

During the intake process, each youth is assigned a room or bed based on the information provided by the youth, parent or guardian, and outside related sources that may have knowledge of the youth's history. Several factors are taken into consideration when assigning a youth to a room including:

Suicide risk

Physical characteristics

Mental or physical disability

Gang affiliation

Aggressive/violent behavior

Identification of youth susceptible to victimization

Level of aggression/attitude at admission

Age/Gender

Gender Identification

There were five youth files reviewed (three open and two closed). All five files documented the youth were assigned a bed during the intake process based on the above mentioned factors. All bed assignments were documented on the intake paperwork as well as initial interactions and observations. Any applicable alerts were documented and entered into the program's alert system.

It is of importance to note that this program has dorm style sleeping areas, one for male youth and another for female youth. There were two staff interviewed and both were able to explain how bed assignments are made and the factors that are taken into account when placing a youth on the top bunk versus the bottom bunk and the front of the room, close to the door, versus the back of the room.

There were no exceptions to this indicator.

## 3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled Log Books to address the requirements of this indicator. This Policy was reviewed and signed on January 4, 2019 by the chief Operations Officer.

The policy of the program states that it is the responsibility of the shift leader to ensure that appropriate documentation occurs on each shift. It also states that the program Log Book shall document, but is not limited to, the following:

- All incidents when physical intervention used

- Intakes and Dispositions of youth

- The staff on duty

- That the security of the building has been checked

- All incidents including when youth leave and return to the general population

- Any current deficiencies in the program

A review of the program log by the incoming shift leader and staff of the previous three shifts in order to be familiar with activity on prior shifts, unusual occurrences, or problems shall be documented.

Weekly review by the Program Manager, Supervisor or designee with corrections, recommendations, directives, or followup shall be documented.

Log books were reviewed for the period of time from August 2018 through December 2018 for this indicator.

It was evident that all safety and security concerns were documented and highlighted appropriately. All entries were brief, legible, and written in ink. Any errors were properly corrected with one line drawn through and marked with initials. Supervisor reviews were documented weekly and shift staff were documenting their review each shift to ensure they were up to date on any pertinent information within the past two to three shifts. Supervision and resident counts were documented clearly with participants first and last name at each shift. Visitation and home visits were documented clearly, as well as phone call times.

There were no exceptions to this indicator.

## 3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place that outlines the Behavior Management System. There are also several additional policies (Rule Violations, Participant/Staff Interactions & Interventions, Seclusion and Restraint & Aggression Control) which help to reinforce the understanding of staff conduct and responsibilities. These policies were reviewed and signed on January 4, 2019 by the Chief Operations Officer.

CDS Central utilizes the FACE System (Facilitating Activity & Communication Effectively) with the intent of increasing youth involvement in the program. Behavioral Expectation forms are reviewed between staff and youth so there is a clear plan designed for each youth to progress.

The FACE System is comprised of three phases: Assessment, Daily, and Achievement. The youth are able to maneuver through the phases, gaining privileges based on their compliance with rules and through demonstrating that they are mastering their targeted skills.

Youth are provided with an orientation packet at intake explaining in detail the Behavior Management System (FACE). There were five Residential files reviewed and there was documentation in each file in the form of a signature indicating that each youth was given this information.

There were six Residential staff training files reviewed. Documentation was found in each file indicating that staff was trained in the Behavior Management System (FACE) during the orientation training period.

There was one Residential staff interviewed and this staff was able to thoroughly outline the Behavior Management System (FACE) and its policy, giving clear examples of how it's implemented with the youth. The staff had an excellent understanding of the process and explained how staff uses points or incentives to encourage positive behavior, as well as negative points to address negative behavior. The staff also reiterated that the FACE system encourages the youth to earn above the minimum goals reinforcing the youth's achievement with more privileges.

There was one youth interviewed. The youth was able to explain their understanding of how the FACE system works. The youth was able to break down the process by presenting the "FACE Book" and described how points are earned for positive behavior and also indicated that you could earn negative points for non-compliant behavior, such as "not participating in groups". It is important to note that this youth has only been in the program for a short time (only a few days); however, did have a clear understanding of the process.

There were no exceptions to this indicator.

## 3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There are two policies, Supervision and Staffing Ratio/Scheduling and Bed Time Supervision and Bed Checks, that address the requirements of this indicator. These policies were last reviewed on January 4, 2019 by the agency's Chief Operations Officer.

Procedures state there must be a minimum of one staff to six youth during awake hours and one staff to twelve youth during the sleeping period. The Regional Coordinator/Designee is responsible for scheduling and ensuring coverage in order to meet DJJ requirements and Florida Administrative Code Chapter 65C-14. Staff are expected to remain on duty until replacement staff arrive to ensure appropriate supervision. There are clear expectations for staff and an established process for them to follow if they are unable to report for their assigned shift. There are identified Shift Leaders who are to use the staff roster to call in staff if needed. Shift Leaders responsibilities are clearly listed within the policy. Each shift should have both male and female staff and there should always be a minimum of two staff on the overnight shift. During asleep hours staff are to conduct room/bed checks every fifteen minutes and should be completed as gender specific bed checks; female staff check female clients and male staff check male clients. Document should be completed in the Program Log Book and only after the completion of the documented task/event. The program uses a Bed Check Scanner Process, there is an outline within the policy explaining how it is to be used.

A random check of five full days of shifts was completed. Dates of the random checks included 8/1/2018, 9/4/2018, 10/22/2018, 11/3/2018, and 1/1/2019. To review this standard there was a cross reference between the daily staff schedule, daily staff shift sign-in log and the program Log Books. The review showed that there were a minimum of two staff on each shift, including overnights, and there were the required number of staff on each shift to ensure there was a one staff to six youth ratio during awake hours and one staff to twelve youth during sleeping periods.

There were two overnight shifts reviewed in which only female staff were scheduled; these dates were 9/4/2018 and 1/1/2019. There was no specific documentation on the staff schedule, staff sign-in log, or in the program Log Book which explained the reason for two staff of the same sex covering the shift. However, the Supervisor provided an approved time off request by the male staff who would normally work the 9/4/2018 shift and the only person able to cover the shift was another female staff. On 1/1/2019, due to it being a holiday many staff were off and since there was only female residents in the shelter at the time two female staff were scheduled to cover the shift.

The staff schedules are kept in a binder labeled Shift Coverage Note Book which is located in the staff office. This binder also has an employee roster with staff phone numbers and email addresses.

Video surveillance and bed check logs were provided to demonstrate that staff observe youth and document this observation every fifteen minutes. A review of four random nights revealed that bed checks were documented every fifteen minutes with one exception. On 12/21/2018 staff documented a bed check was conducted at 1:27am; however, when reviewing video surveillance this bed check was not actually

conducted and there was a thirty minute gap during that time frame with no bed check. The Residential Supervisor reported this incident to the CCC for "falsification of documentation."

There are no exceptions to this indicator.

### 3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The following are the policies related to special populations; Staff Secure Shelter-Program Overview, Staff Secure Shelter Services, Domestic Minor Sex-Trafficking, Domestic Violence Respite, Probation Respite, and Family/Youth Respite After Care Services (FYRAC) Non-Residential Services. All these policies were last reviewed on January 4, 2019, by the agency's Chief Operations Officer.

Staff Secure Procedures: Youth served must meet the requirements in Chapter 984 of Florida Statute, there is an in-depth orientation upon admission to the program which tend to planned admissions which provided the opportunity of a more intensive intake process, there is a comprehensive assessment process which then allows for the development of an individualized service plan, the program provides enhanced supervision with designated staff assigned to the client at all times. The Program Log Book is used to ensure all required and important information is documented. Parent involvement is encouraged and opportunity to be involved in the service planning is provided. The programs goal is also to provide the parents with the necessary skills, resources and supports to strengthen their family. The program works to provide Collaborative Aftercare; at the discharge phase the youth's placement is done in conjunction with the court, parents, youth and referring CINS/FINS provider.

Domestic Minor Sex Trafficking Procedures: Youth served must be approved by the Florida Network. Services are approved for a maximum of seven days with additional approval needed beyond that time which will be obtained on a case by case basis. The agency uses NetMIS to track youth being served in special population. The agency individualizes the youths services and makes any needed adjustments to their schedule to encourage the youth to remain in the shelter.

Domestic Violence Respite Procedures: Youth served have been arrested for domestic violence and referred by DJJ and do not meet detention criteria and are unable to immediately return home. Youth must meet the requirements under Chapter 741 of Florida Statue. Youth ages 10 years old up to 18 years old can be served and could have prior adjudication, be on probation and/or be involved with DFC. Services are provided up to 14 days additional days can be provide but can't exceed 21 days. The agency had ineligible criteria focused on safety and well-being of the youth and other clients in the shelter. Services provided is consistent with all other CINS/FINS program requirements.

Probation Respite Procedures: Youth served have to be between ages 10 years old up to 18 years old and be referred by DJJ Probation. Youth has to be on probation with adjudication being withheld. The length of the youth's stay is between 14 and 30 days which is determined at the time of admission. Any stay beyond 30 days required approval by the Chief Probation Officer and Florida Network. Services provided is consistent with all other CINS/FINS program requirements.

Family/Youth Respite After Care Services (FYRAC) Non-Residential Services Procedures: Youth served have to be referred by DJJ for domestic violence and meet Florida Network policy requirements. Services provided is consistent with all other CINS/FINS program requirements.

The program has not served any Staff Secure, Domestic Minor Sex Trafficking, Probation Respite, or FYRAC youth since the last on-site review.

There were three youth files reviewed for Domestic Violence (DV) Respite services. All three files had a referral form the Department of Juvenile Justice (DJJ) in the case file showing that each case had been screened. All three youth had been arrested for domestic violence. In addition to the referral each file had a DJJ face sheet. One file had an email from the JPO Supervisor with additional details related to the case. Of the three cases only one stayed for the full twenty-one days and the other two were in shelter for less than 72 hours. None of the cases exceeded twenty-one days. Due to two of the three cases being in shelter for less than 72 hours, both were in shelter for around 48 hours, neither one had a Case Plan completed. The other case had a completed Case Plan with identified goals of: Be able to manage anger and Be able to coexist without physical altercation. The program provided CINS/FINS services to all three youth during their stay regardless of the length of stay. These services included: individual counseling, groups, daily shelter activities, and aftercare with referrals to additional services.

There are no exceptions to this indicator.

### 3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place titled Video Surveillance to address the requirements of this indicator. The policy was last reviewed on January 4, 2019 by the agency's Chief Operations Officer.

The camera system operates and records twenty-four hours a day seven days a week, even during times of power outage, with date, time, and location. The system is to keep a recording for a minimum of thirty days with ninety days being preferred. All cameras are to be visible and there shall be a written notice of cameras use upon entering the shelter. Cameras should be placed outside, as well as inside the shelter where staff and youth congregate. Cameras shall not be placed in bathrooms or sleeping quarters. Supervisor camera reviews are to be conducted bi-weekly and noted in the log book. Camera footage is restricted and access is determined by the program administrator. Review of any footage is to be handled in a professional, ethical and legal manner. Requests for video recordings for QA/audits and investigations are available within 24 to 72 hours.

The program has a camera system with fifteen cameras. These are located internally, as well as externally and are all visible. Cameras are located at the front door, back door, blue room, back hallway, conference room A, conference room B, lunch room, achievement room, computer room, kitchen, girls dayroom, boys dayroom, basketball court, control room, and front drive. There are no cameras in the bedrooms or bathrooms. There are posted notices at each of the main entrances stating cameras are in use. The system is able to records twenty-four hours a day seven days a week including date, time and location. The system can retain recordings up to ninety days. The system has a backup battery that will allow the system to continue to record up to an hour if the power was to go out. The system is able to capture video that allows for facial recognition. The only two individuals within the shelter who have access to the camera system are the Residential Supervisor and Regional Coordinator. The Residential Supervisor completes video reviews bi-weekly the documentation of these reviews can be found in the front of the program Log Books. All reviews included random samples of overnight bed checks. In a situation in which an outside request for video recording is being made that request is handled by the Residential Supervisor who then pulls the requested footage. Assistance from the IT Department maybe requested as well.

There are no exceptions to this indicator.

# Standard 4: Mental Health/Health Services

## Overview

Rating Narrative

The CDS Central program has specific policies and procedures related to the admission, screening, interviewing, client inventory, and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. Upon admission, program staff will conduct a full intake interview with the youth and parent/guardian. An initial assessment occurs to determine the most appropriate room assignment given the youth's needs and issues, the current population at the facility, physical space available, and staff's assessment of the youth's ability to function effectively within program rules and expectations. CDS Central staff members conducting the initial interview and assessment considers the residents' health and mental health status, physical characteristics, maturity level, history including gang or criminal involvement, school performance, and family dynamics. Staff members on duty at the time of admission immediately identify youth who are admitted with special needs and risks; such as risk of suicide, mental health, substance abuse, physical health, or security risk factors. The agency's Non-Residential Regional Coordinator is a Licensed Mental Health Counselor (LMHC).

When a youth indicates positive for suicide risk they are placed on Constant Supervision or One-to-One Supervision. The agency utilizes a daily logbook documentation system and an alert board as part of its internal medical/mental health alert system. The agency operates a detailed medication distribution system using the Pyxis Med-Station 4000 Medication Cabinet.

The program has a Registered Nurse (RN) on-site at least five days a week. The shelter has a list of staff members that are authorized to distribute medication. The facility is equipped with multiple first aid kits, knife for life and wire cutters. The staff are trained to provide CPR and First Aid services in case of an emergency. Staff members are also trained on fire safety techniques and various emergencies. As of the date of this onsite review, all fire safety equipment is up-to-date and functioning as required.

## 4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled Preliminary Physical Health Screening and a policy titled Medical Follow-Up, to address the requirements of this indicator. The policies were last reviewed on January 4, 2019 by the Chief Operations Officer.

The policies state each youth will be provided a preliminary physical health screening and staff will also complete the Intake Assessment Form. Information obtained from the youth's initial screening is recorded on the Intake Assessment form and the staff person completing the form will note on page 6 if there are any areas of concern or needed follow-up and will initiate the Medical/Mental Health Alert System. The youth and parent/guardian will also be interviewed upon admission about the youth's current medications. This is part of the Medical and Mental Health Assessment Screening process. This process is conducted by a Registered Nurse (RN) if one is on-site. Otherwise, this interview will be conducted by on-duty staff and reviewed by the RN within five business days. The Supervisor/Shift Leader on duty will review the youth's intake packet to assess the need of any immediate action.

Any medical conditions requiring a follow-up shall be addressed to determine the need for medical attention. In these situations, guidance should be sought from the parent/guardian or if unavailable a health care professional. In circumstances where uncertainty prevails a supervisor should be consulted.

Once the intake process is complete, the intake staff person and a supervisor or shift leader reviews the intake packet including the Intake Assessment form. Any health concerns that require a follow-up are addressed at that time through consultation with the parent/guardian and documented on a Medical Health Follow-Up form. If the parent/guardian is unavailable, attempts are made to contact the youth's physician. In the case of an emergency, 911 is contacted for assistance. In situations where no immediate concerns are noted, the assigned counselor is responsible for follow-up with the parent/guardian on any health issues.

A total of five files, four open and one closed, were reviewed to assess requirements of this indicator. Of the five files reviewed, all contained the Intake Assessment form with all health screening sections completed on the day of admission. Four of the five files reviewed documented the youth were on medications. The medications were listed, as well as, the reasons for the medications. Four of the files documented the youth had some type of allergies. Three youth were documenting as having Asthma; however, none of the youth required any type of medication for the condition. The Intake Assessment form was reviewed by the RN within five working days in all five files.

The agency utilizes a Medical Health Follow Up form. This form aids the staff regarding any health issue that has been confirmed during the health admission screening. Once a staff person identifies a major health issue a specific form with information on the health issue is placed in the youth's file. The form is designed to help increase awareness and knowledge of staff serving the youth of any potential health symptoms or identifiers for them to be aware of. This form is only utilized for specific health issues. In the five files reviewed, all five had this form. Three of the files had a follow-up form for Asthma and four files had a follow-up form for Allergic Reactions.

Out of the five files reviewed, two youth documented dietary allergies. One youth was allergic to seafood and one youth had a peanut allergy. Both files documented a Special Diet form was completed. One youth did not eat meat and a Special Diet form was completed for this youth as well. The Special Diet forms documented the youth's special diet needs and supporting information, if any items will be provided from the

guardian, and any special concerns that should alert staff to contact guardians related to the special diet.

There were no exceptions to this indicator.

### 4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled Suicide Assessment and a policy titled Mental Health, Substance Abuse, and Suicide Risk Screening to address the requirements of this indicator. These policies were last reviewed on January 4, 2019.

The initial suicide risk screening consists of the six questions on the Intake/Assessment form. If a youth answers "yes" to any of the six questions the youth will be placed on constant sight and sound supervision until a full suicide assessment is conducted. If the youth is an immediate danger to themselves or others the youth will be placed on one-to-one supervision and staff will immediately call 911 and request assistance for law enforcement for a baker act. If at any time during the youth's stay in the shelter, the youth expresses any suicidal thoughts or ideations the youth is placed on constant sight and sound supervision until a full risk assessment is completed by a qualified staff.

The agency has two levels of supervision. One-to-one supervision is the most intense level and is used for youth waiting to be removed from the program by law enforcement for a baker act. One staff member, who must be the same gender as the youth, will remain within arm's length of the youth at all times. The second level of supervision, Constant Sight and Sound Supervision, is for youth who are identified as being high risk of suicide but are not expressing current suicidal thoughts or threats. A staff member must have continuous, unobstructed, and uninterrupted sight of the youth and be able to hear the youth. Staff assigned to monitor the youth must document his/her observations of the youth's behavior at intervals of thirty minutes or less for both one-to-one supervision and constant sight and sound supervision.

The shelter employs two master’s level counselors who complete all suicide risk assessments on youth in the shelter. Both staff have received training to complete the assessments and are supervised by The agency's Non-Residential Regional Coordinator is a Licensed Mental Health Counselor (LMHC). Both counselors consult with the LMHC prior to removing any youth from suicide precautions.

There have been  two youth who have been placed on suicide precautions in the last six months. Both files were closed files. One youth was placed on suicide precautions at intake due to issues identified during the screening process and the other youth was placed on during a stay in the shelter due to making self-harming comments. Both youth were placed on sight and sound supervision. Both youth were seen and assessed, by a master’s level counselor, within twenty-four hours. Both files documented a suicide risk assessment was completed by a master’s level counselor and documented consultation with the LMHC and program director. Both the LMHC and program director signed the assessments prior to the youth being removed from suicide precautions. The youth were placed on normal supervision. Both youth had thirty minute observations documented the entire time on suicide precautions.

There were no exceptions to this indicator.

### 4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled Medication Provision, Storage, Access, Inventory, and Disposal to address the requirements of this indicator. The policy was last reviewed on January 4, 2019 by the Chief Operations Officer.

The policy has detailed procedures for Prescription Medication, Verification of Medication, Medication Provision, Supervision, and Monitoring, Utilization of the Pyxis Med-Station 4000, Proper Storage of Medication, Medication Inventory, Medication Counting Procedures, Medication Errors and Refusals, Discharge of Youth with Medication, and Disposal.

The shelter provided a list of thirty staff who are trained to supervise the self-administration of medications. There were two staff on that list who were listed as “Super Users” for the Pyxis Med-Station.

The shelter has a RN who has been employed at the shelter since April 2018. The RN is on-site seven days a week, totaling approximately twenty hours a week. The RN is on-site every evening, Monday thru Friday, from approximately 6pm until 9pm, and every Saturday and Sunday morning. The RN distributes all medications when onsite and the shift leader distributes any medications when the RN is not on-site. The RN does complete various trainings with the staff, including medication administration. The RN reported most discrepancies produced by the Pyxis Med-Station were staff getting confused with the beginning count versus the actual count. These discrepancies were easily fixed by the RN or the staff member. However, the RN reported these discrepancies were not being closed out by the end of the staff members shift and are usually closed out within two to three days. At the time of the review the shelter had no open discrepancies. The RN reported not using the Knowledge Portal to run reports.

All youth medication is stored in the Pyxis Med-Station. Each medication is stored in its own separate bin within the Med-Station so topical

medications are always stored separately. Only the youth's prescription medication is stored in the Pyxis Med-Station. Medication storage will start in drawer one and once that drawer is full will continue into drawer two and so on. Drawer two, however, is primarily used for controlled medications. The shelter has a system in place for refrigeration of medication if needed. At the time of the review there was no medication requiring refrigeration. The refrigerator was locked and once opened was observed empty and the thermometer read 36 degrees.

All medications in the shelter are inventoried once per week, by the shift leader. This inventory is documented on the back of each individual Medication Record Log (MRL). All medications are also inventoried at admission with the parent present, when given, by maintaining a perpetual inventory with running balances, and at discharge also with the parent present. Controlled medications are inventoried shift-to-shift also. The shelter does not have any over-the-counter medications.

There was one youth in the shelter on medication and that file along with six closed files were reviewed for medication administration. The agency still maintains hard copies of all documents relating to the medication process and enters all information into the Pyxis Med-Station, as required. The youth's MRL's are maintained in the youth's individual file. All MRLs reviewed, documented the youth's name, a picture of the youth, allergies, medication the youth was taking with dosage and time to be given, method of administration, side effects/precautions, special procedures/instructions, staff initials, youth initials, full printed name and signature of each staff member who initialed a dosage, and the full name and signature of the youth receiving medication. The back of the MRL documented all daily and weekly inventories and the verification of the medication with the pharmacist or by the RN.

All seven files documented the youth received medications at prescribed times. Perpetual inventories with running balances were maintained. Out of the seven files, there were four different controlled medications reviewed. All controlled medications were inventoried each shift. Weekly inventories were completed for the non-controlled medications.

The shelter has had five CCC reports relating to medication errors in the last six months. All five errors occurred during the months of July and August 2018. All five errors were due to a youth missing a dose of medication. There was documentation in all five cases of staff being re-trained by the RN on policies and procedures, verbal warning memorandums, corrective action memorandums, and/or verbal counseling memorandums. The agency also conducted several all staff trainings on the medication policies and procedures. In addition, the medication policies and procedures were discussed at several of the all staff meetings during the time frames surrounding the errors. As a result of the corrective actions and re-trainings completed there have not been any medications errors since the last one August 25, 2018.

Discrepancies were not being closed out by the end of the staff's shift.

The RN is not currently using the Knowledge Portal for monthly reviews of medication management practices.

## 4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled the Medical and Mental Health Alert Process to address the requirements of this indicator. The policy was last reviewed on January 4, 2019 by the Chief Operations Officer.

Upon admission to the shelter, each youth receives a preliminary medical, mental health, suicide risk, and substance abuse screening. Any conditions are noted on the Intake/Assessment Form. All medication the youth is taking is listed on the Intake/Assessment Form and the Medication Record Log. Medication allergies, food allergies, and any other allergies are noted on the Intake/Assessment Form, the medical record log, and on the outside cover of the youth's file with either an "Allergy" or a "Medical/Mental Health Alert" label. In addition, youth issues, concerns, conditions, or physical restrictions are noted on the youth board using appropriate codes. All incoming staff review the youth board beginning of each shift.

A review of three open youth files and four closed files was conducted to verify the shelter's alert process. All seven files documented any applicable alerts on the spine of the youth's file. All medical related information was documented on the Intake/Assessment Form inside the file. All alerts documented on the youth's files corresponded with alerts documented on the alert board in the staff office, for the open files. Alerts on the board were coded with numbers 1-18, with each number representing a different alert. Any dietary alerts/special diets were also documented on a separate form in the youth's file and in the kitchen.

There were no exceptions to this indicator.

## 4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled Episodic Emergency Care that addresses the requirements of this indicator. The policy was last reviewed on January 4, 2019 by the Chief Operations Officer.

There are procedures in place for staff to follow in various types of medical emergency situations such as: Skin Wounds, Fractures or Sprains, Dental Trauma, Nose Bleeds, Poisons, Convulsions/Seizures, Head Injuries, Stings and Bites, Burns and Scalds, Electrical Burns, and Accessing Emergency and Dental Care in Residential Shelters. Emergency drills simulating these events and other potential situations are to be conducted quarterly on various shifts. These drills should be critiqued and discussed during staff meetings.

Each program maintains its own first aid kit and supplies. The Regional Coordinator or his/her designee is responsible for ensuring adequate supplies are available for use and stored in areas in the facility that are accessible to staff. The first aid kits should be inventoried as a part of the weekly safety inspection and restocked as necessary. A knife-for-life and small wire cutters shall be maintained in a secure area accessible to staff in the event of a youth suicide attempt. All staff in direct contact with youth are to be certified in CPR and First Aid.

There have been four off-site emergency care events in the last six months. The shelter maintains an Emergency and Episodic Care Log that documents the date, youth involved, service needed, if the parent was notified, notification to the CCC, and discharge instructions. There was also an incident report completed for each event that documented a more detailed explanation of the incident, all notifications, and discharge instructions. Each incident was also found documented in the program logbook. The shelter has completed a Medical Emergency Drill on each shift for the last quarter.

First aid kits are located in the staff office and in both the vans. The kits are checked weekly for expiration dates and replenished as needed. The shelter has both a knife for life and wire cutters in the staff office.

All employees at the shelter had current first aid and CPR certifications.

There were no exceptions to this indicator.