



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of SM ACT Behavioral Health Center

on 09/27/2018

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 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 |
| 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 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
- Amy Tyson, South Regional Monitor, DJJ
- Jennifer D'Amato, Senior Children's Services Counselor, OCYFS
- William Thomas, CINS/FINS Truancy Navigator, Bethel Community Foundation
- Christopher Bradshaw, Shelter Supervisor, Boystown

Persons Interviewed

- | | | |
|---|--|---|
| <input checked="" type="checkbox"/> Chief Executive Officer | <input type="checkbox"/> Executive Director | <input checked="" type="checkbox"/> Chief Operating Officer |
| <input type="checkbox"/> Chief Financial Officer | <input checked="" type="checkbox"/> Program Director | <input type="checkbox"/> Program Manager |
| <input checked="" type="checkbox"/> Program Coordinator | <input checked="" type="checkbox"/> Direct- Care Full time | <input type="checkbox"/> Direct-Care Part Time |
| <input type="checkbox"/> Direct-Care On- Call | <input type="checkbox"/> Volunteer | <input type="checkbox"/> Intern |
| <input checked="" type="checkbox"/> Clinical Director | <input checked="" type="checkbox"/> Counselor Licensed | <input checked="" type="checkbox"/> Counselor Non- Licensed |
| <input checked="" type="checkbox"/> Case Manager | <input type="checkbox"/> Advocate | <input checked="" type="checkbox"/> Human Resources |
| <input checked="" type="checkbox"/> Nurse | | |
| 1 Case Managers | 0 Maintenance Personnel | 2 Clinical Staff |
| 1 Program Supervisors | 0 Food Service Personnel | 0 Other |
| 2 Health Care Staff | | |

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" 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 checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 # 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 | 9 # 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

5 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 checked="" 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 Adolescent Campus has undergone the following changes. Previously BEACH House had:

- Director of Adolescent Residential Services
- Assistant Director of BEACH House
- Two Shift Managers

The program now has:

- Director of Adolescent Residential Services
- Operations Manager
- Three Operations Supervisors

Pam Palmer was promoted as the new Director of Adolescent Residential Services.

Amanda Selvage is the new Manager of Operations.

Paul Hatto went from Assistant Director of BEACH House to Operations Supervisor.

Kimberly Stone went from Shift Manager to Operations Supervisor.

Manuel Ruiz was hired as the new Operations Supervisor. He is in training.

Barbara Jordan-McGill was hired as the new CINS/FINS Case Manager.

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 agency has a policy titled Background Screening of Employees/Volunteers. The effective date of the policy was listed as July 1995 and was last reviewed on September 10, 2018 by the Director of Adolescent Residential Services.

The procedures require 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 Level 2 Screening Standards" be submitted to the Department's Background Screening Unit by January 31 each year.

Seven newly hired staff were reviewed for initial background screening. An initial background screening was completed prior to the date of hire date for all seven staff. There were no staff requiring a five year re-screening during this review period.

The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the DJJ background screening unit prior to the January 31st deadline.

The agency uses ApplicantStack for their application and screening process for all new hires. The applicant is required to answer a set of questions based on the position applying for that will either qualify them for the position or possibly make them ineligible for the position. After those set of questions are answered and if the applicant makes it through then the agency can choose an additional set of screening questions to send the applicant to answer to gain further knowledge of the applicant's skills, abilities, and suitability for the position prior to interviewing the applicant.

There were no exceptions to this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory

 Limited

 Failed

Rating Narrative

The agency has a policy regarding Provision of an Abuse Free Environment. The policy was reviewed September 10, 2018.

Program staff adhere to a code of conduct that prohibits the use of physical abuse, profanity, threats, or intimidation. Any person who has reasonable cause to suspect that a child is abused, abandoned, or neglected reports such knowledge or suspicion to the Florida Abuse Hotline. The program has an accessible and responsive grievance process for youth to provide feedback and address complaints. Management takes

immediate action to address incidents of physical and/or psychological abuse, verbal intimidation, use of profanity, and/or excessive use of force.

There are postings of the Florida Abuse Hotline throughout the program. Management takes immediate action to address incidents of abuse. Incidents of suspected abuse were reported to the Florida Abuse Hotline and documented on the Occurrence Report form. Additionally, the program provides an accessible and responsive grievance process for youth to provide feedback and address complaints. Grievance forms are located in the living area. The grievance process has three phases: informal, supervisor phase, and program director phase. There is a locked grievance box available to youth. During the review period there was one grievance filed. The grievance was addressed by the supervisor and the youth was satisfied with the outcome and did not wish to pursue the grievance further.

There were five youth surveyed. Four out of the five youth reported they are aware the Abuse Hotline is available to them. Two of the youth reported knowing where the number is located and all five youth reported they have never attempted to call hotline but also have never been stopped from calling the hotline. All five youth reported that staff are respectful. Three youth reported they have never heard a staff member use inappropriate language and two youth reported they have.

There were eighteen staff surveyed. All staff reported they have been trained on the Abuse Hotline procedures and have never heard a co-worker denying a youth access to the hotline. Fourteen out of the eighteen staff reported they direct the youth to place completed grievances in the grievance box. Four staff reported they direct the youth to turn the grievance in to a shift manager.

There were no exceptions to this indicator.

1.03 Incident Reporting

Satisfactory Limited Failed

Rating Narrative

The agency has a policy regarding Incident Reporting Procedure which was reviewed September 10, 2018.

The procedure for incident reporting states whenever a reportable incident occurs, the program notifies the Department's Central Communication Center (CCC) within two hours of becoming aware of the incident. The program also 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.

Reports to the Central Communications Center were reviewed for the past six months. In the past six months there have been seven incidents which required reporting to the Central Communications Center (CCC). Six of seven were called in within the required two-hour time frame and one was called in the next day. All calls were related to medication errors. All calls were documented in the program's log books. Follow up was completed as required.

There were no exceptions to this indicator.

1.04 Training Requirements

Satisfactory Limited Failed

Rating Narrative

The Training Policy states staff will receive training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions. The policy was last reviewed September 10, 2018.

All direct care CINS/FINS staff shall have a minimum of eighty hours of training for the first full year of employment and forty hours of training per year after the first year. The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign in sheets, and agendas for each training attended.

A random sample of nine training files were reviewed. Of these files, all were current employees with four representing recently hired staff and five representing staff that have been employed with the agency over six years.

Of the four training files for recently hired staff, one was reviewed for completion of all first year requirements, and three were reviewed only for completion of trainings which are required during the first 120 days of employment. This staff was hired December 11, 2017. He has completed all required trainings within the required time frames with the exception of Managing Aggressive Behavior which should have been completed within the first 120 days of employment.

Of the three staff reviewed for completion of training required in the first 120 days, two staff completed all required trainings. One staff member did not complete Universal Precaution training, and completed the following trainings outside of the 120 day time frame: Signs and Symptoms of Mental Health and Substance Abuse, CINS/FINS Core Training, and Suicide Prevention in addition to the required SkillPro courses.

Five staff training files were reviewed for annual training requirements. Out of the five files reviewed, two staff received at least forty hours of

training for the year. Four staff completed Suicide Prevention part one and two in SkillPro. Four staff had documentation of completing CPR and First Aid. Four staff also had documentation of completing Managing Aggressive Behavior. Three staff's training documentation indicated completion of Fire Safety Equipment training. All five staff completed Prison Rape Elimination Act training within the past two years, Sexual Harassment training, and Human Trafficking 101.

The program maintains an individual training file for each staff within a training binder, which includes an annual training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.

Exception:

One file reviewed for training completed during the first 120 days did not complete Universal Precaution training, and completed the following trainings outside of the 120 day time frame: Signs and Symptoms of Mental Health and Substance Abuse, CINS/FINS Core Training, and Suicide Prevention in addition to the required SkillPro courses. Another staff did not receive Managing Aggressive Behavior in the first 120 days.

Three staff received less than the required forty hours of annual training with twenty-two, twenty-five, and thirty-one hours respectively. One staff was missing the following trainings: Suicide Prevention part one and two. The second staff was missing the following: CPR, First Aid, and Fire Safety Equipment. The final staff was missing the following trainings: Managing Aggressive Behavior and Fire Safety Equipment.

1.05 Analyzing and Reporting Information

Satisfactory Limited Failed

Rating Narrative

The agency has a policy in place for Analyzing and Reporting Information. The policy was last reviewed September 10, 2018.

The program collects and reviews several sources of data to identify patterns and trends. This information includes monthly review of NetMIS data reports, performance improvement standards, occurrence reports, and safety concerns. Additionally, a quarterly review of case record review reports, incidents, accidents, and grievances. Annually, customer satisfaction data, and outcome data is reviewed.

There is a monthly review of all occurrences which includes: safety/security issues, injuries, abuse reporting, accidents, and grievances. Additionally, occurrence reports are reviewed with staff during monthly staff meetings. Annually, a Performance Improvement Executive Summary is produced which details evidenced based practices, performance measures, and review of client satisfaction surveys.

There were no exceptions to this indicator.

1.06 Client Transportation

Satisfactory Limited Failed

Rating Narrative

The facility has a policy regarding client transportation to avoid situations that put youth or staff in danger of real harm or perceived harm, or allegations of inappropriate conduct by either staff or youth. The policy was reviewed September 10, 2018.

Approved agency drivers are agency staff approved by administrative personnel to drive clients in agency or approved vehicle. Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy. Third party is an approved volunteer, intern, agency staff, or other youth. Documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.

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. There were very few instances of one staff transporting a single client and supervisory approval was documented in the logbook when it did occur. Since all youth attend school on-site, the number of off-site transports are limited.

There were no exceptions to this indicator.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The facility has a policy regarding Interagency Agreements and Outreach which was reviewed September 10, 2018. The policy outlines the types of agreements SMA Behavioral Inc. enters into in order to best serve families in the community and the Outreach services provided in order to raise public awareness of CINS/FINS services and the ongoing issues of runaway youth.

The Interagency Agreements allow for the interchange of information in order to serve clients in a cohesive manner. These agreements are reviewed annually and updated as needed due to changes in services or staffing in order to maintain open relationships to keep the agreements current. The Outreach component's goals are to provide protection and safety to children in need, assume leadership as a unifying force for community based prevention programs by drawing on community strengths and resources, and linking information and services to assist children and families in trouble.

The program maintains written agreements with community partners which include services provided and a comprehensive referral process. These community partners include Volusia County Schools Alternative Education Program, Domestic Abuse Council, local universities, Florida Department of Health, and New Start. The goals of the outreach services include: strengthen family relationships and encourage stable living conditions for youth, provide services related to the needs of the runaway and homeless youth, provide safe supportive environment conducive to the type of connections that are known to be healing and strengthening to run away and homeless youth.

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 Needs Assessment on each youth within 72 hours of admission or within two to three face-to-face contacts for youth receiving Non-Residential services. These Needs Assessments 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 Needs Assessment, 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 Needs 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 in place for Screening and Intake. The policy was last reviewed on September 10, 2018.

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.

The agency ensures that youth and parents/guardians receive the following in writing during intake: Available service options; Rights & Responsibilities of youth and parent/guardians; possible actions occurring through involvement with CINS/FINS services; and grievance procedures.

A total of five Residential files were reviewed; two open and three closed. All files reviewed demonstrated that an initial screening for eligibility occurred within seven calendar days of referral. 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.

A total of five Non-Residential files were reviewed; three open and two closed. 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.

There were no exceptions to this indicator.

2.02 Needs Assessment

Satisfactory

 Limited

 Failed

Rating Narrative

The agency has a policy in place for Needs Assessment that was last reviewed on September 10, 2018.

The procedures require that upon entry to the Residential Program, each youth shall receive a Needs Assessment initiated within 72 hours of admission. If the most recent Needs Assessment is over six-month old a new, a full Needs Assessment will be completed. For Non-Residential services the Needs Assessment must be initiated during the first face-to-face session and completed within three face-to-face visits/sessions. The policy indicates that if more intensive assessments or evaluations are necessary a referral will be made. Assessments are on-going throughout the client's duration of services and may require further assessment as other issues arise.

There were five Residential files reviewed; three closed and two open. All Needs Assessments were completed within 72 hours of admission by a Bachelor's or Master's level staff member. Signatures from the supervisor were present on the Needs Assessments and the suicide risk component of the assessment was provided to the youth as needed.

A total of five Non-Residential files were reviewed; two closed and three open. 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 Assessments 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.

There were no exceptions to this indicator.

2.03 Case/Service Plan

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a policy in place for Case/Service Plans that was last reviewed on September 10, 2018.

The agency has a procedure in place for Case/Service Plans that is developed between designated BEACH House Staff, the youth, and family. According to the program manual, the plan shall address the specific needs identified in the Needs Assessment and on the Integrated Assessment Summary. Service Plans are to be completed on the Service Plan forms and include specific needs for the youth and family, type, frequency, and location of services, persons responsible, and target dates for completion. The procedure requires Service Plans to be signed by the youth and parent/guardian.

There were five Residential files reviewed; three closed and two open. All files reviewed demonstrated a Case/Service Plan was developed within seven working days following completion of assessment. All goals were individualized and included prioritized needs and goals identified by the Needs Assessment. All files included signatures of youth, counselor, and supervisor.

A total of five Non-Residential files were reviewed; two closed and three open. All five files had the Case/Service Plan developed within seven working days of Needs Assessment. All five plans reviewed documented: the individualized and prioritized needs and goals identified by the Needs Assessment, the service type, frequency, and location for the Case/Service Plan. All five files had the persons responsible and the target dates 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. Two of the five files (closed files) had the completion/termination dates of the goals.

None of the Residential Case/Service Plans reviewed included actual completion dates of any goals once completed.

2.04 Case Management and Service Delivery

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a policy in place for Case Management and Service Delivery that was last reviewed on September 10, 2018.

The agency has a procedure in place for Case Management and Service Delivery that includes information regarding coordinating service plan implementation, monitoring youth/family's progress in services, and referrals to the case staffing committee and judicial action.

The procedure does not include details regarding youth assignment to a counselor/case manager for delivery of services. It does not include the process of case management in establishing referral needs and coordinating referrals to services, providing support for families, monitoring out-of-home placements, accompanying youth and families to court hearings and related appointments, referrals to additional services, continued case monitoring and review of court orders, and case termination with follow up.

There were five Residential files reviewed; three closed and two open. Based on the files reviewed, youth were assigned a primary counselor for services including: service plan implementation, referrals to other services, support for families, monitoring out-of-home placement, case

monitoring, and case termination with follow-up. None of the files required monitoring of out-of-home placement.

A total of five Non-Residential files were reviewed; two closed and three open. 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.

There were no exceptions to this indicator.

2.05 Counseling Services

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a policy in place for Counseling Services that was last reviewed on September 10, 2018.

According to the program manual, youth and families receive counseling services according to the youth's case/service plan to address the needs identified during the assessment process. The shelter program provides individual and family counseling, as well as group counseling conducted a minimum of five days per week. The program's counseling services must reflect all case files for coordination between presenting problems, BPS assessment, case plan, case plan reviews, case management and follow up; maintain individual case files on all youth and adhere to laws regarding confidentiality; maintain chronological case notes on youth's progress; and maintain an on-going internal process that ensures clinical review of case records, youth management, and staff performance regarding CINS/FINS services.

The procedure does not include that groups be conducted by staff, youth, or guests. It does not include the requirement of documentation of groups in regard to date/time, participants, length of time, and topic; or that groups are not intended to be therapy.

There were five Residential files reviewed; three closed and two open. Based on the files reviewed, case plans were developed based on youth's needs. 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.

There were five Non-Residential files reviewed; two closed and three open. All five files had youth's presenting problems addressed in the Needs Assessment, had the youth's presenting problems addressed in the initial Case/Service Plan, and the 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 youth and families receive counseling services in accordance with the Case/Service Plan, and that the program provides individual/family counseling.

There were no exceptions to this indicator.

2.06 Adjudication/Petition Process

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a policy for the Adjudication/Petition Process that was last reviewed on September 10, 2018.

The Case Staffing Committee is used for cases that require additional assistance beyond the CINS/FINS service provider when a client is not being successful with program goals. The Committee is devised of representatives from a variety of agencies to ensure all treatment and service options have been explored and exhausted prior to referring cases to CINS/FINS court.

The Service Manager shall arrange for a meeting of the Case Staffing Committee if it is determined: The youth or family have not demonstrated substantial progress in achieving the service plan goals; The services or treatments selected have not have not addressed the youth's or family's needs; or The family or youth will not participate in the services or treatments selected.

Upon scheduling the Case Staffing meeting, the Case Managers will notify appropriate parties to attend within at least five working days of the scheduled committee meeting to confirm the time of the meeting. Appropriate parties include, but are not limited to: Youth; Family; Guardian; School personnel; and Other providers.

Service managers will send the notification out via certified mail to parents/guardians and regular mail to other attendees and additional reminders via phone calls.

Parents/legal guardians shall be informed of their ability to request a convening of the Case Staffing Committee and the ensuing process during their initial meeting with the service manager. The Service Manager shall convene a meeting of the Case Staffing Committee within seven working days after the receipt of a written request from a parent.

At the Case Staffing meeting the Committee, youth and family/legal guardian shall arrive at a plan of service. A decision to take judicial action constitutes a plan of service. The youth and parent/legal guardian shall be provided a copy of the plan of service at the meeting. The service plan is the written report for the case staffing. Should the youth and family not receive a copy of the recommendation at the time of the case staffing meeting, a copy of the written plan shall be sent to the parent/legal guardian within seven days of the case staffing meeting. The plan will outline the reason for the committee's recommendation either for or against a petition being filed for judicial action.

The case staffing service plan will be recorded on the CINS/FINS committee Interagency Release on Information form. The committee recommendation with all attendees' signatures and the committee recommendations will be recorded on this form and placed in the youth's medical record. If the youth is currently receiving services for CM ACT, a copy of the committee recommendation form will be faxed to staff and placed in the medical records for continuity of care purposes. At least two case staffing meetings will be held before the service manager files a petition for judicial action.

There were two files reviewed for Case Staffing compliance. The staffing's were initiated by the Service Manager. Families were notified of the staffing no less than five working days prior to the staffing. The local school district representative, the DJJ representative and the CINS/FINS provider were present at the staffing's. The youths' mothers and school social workers also attended the staffing, as well as, a mental health representative. As a result of the Case Staffing Committee meeting, the youth 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 that was last reviewed on September 10, 2018.

The agency has a procedure for Youth Records that require all records be marked "confidential" and kept in a secure room or locked file cabinet that is marked confidential, which is accessible to program staff. The procedure also requires that youth records are maintained in a neat and orderly fashion for easy access by staff and that all records 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.

2.08 Sexual Orientation, Gender Identity/Expression

Satisfactory Limited Failed

Rating Narrative

The agency has a policy in place to ensure a safe environment and therapeutic case planning for all youth regardless of the actual or perceived sexual orientation, gender identity, or gender expression. The policy has an effective date of September 2018.

The procedure for implementing this policy will be completed by all staff following the protocols set in place. Firstly, the youth will be addressed by their preferred name and gender pronouns, all staff are prohibited from discussing the youth's sexual orientation, gender identity, or gender expression, any and all harassment by youth will be reported to the DCF Abuse hotline, and no staff will be prohibited from attempting to change a youth's sexual orientation, identity, or gender expression.

All staff, service providers, and volunteers will have knowledge of this policy. If the youth need specialized support or services relative to their sexual orientation, gender identity, or gender expression, the service provider is required to refer these youth to services or request assistance from the Florida Network in identifying qualified resources and providers. Areas where the youth reside or are served will have signage indicating the program is a safe place for all youth regardless of actual or perceived sexual orientation, gender identity, or gender expression.

All youth will be identified in the logbook and all public facing documents by their preferred name and gender pronouns. The youth will be assigned to a room aligning with their gender identity or the program will provide specific documentation as to why another room assignment was determined. Youth will not be housed in isolation solely based on actual or perceived sexual orientation, gender identity, or gender expression. Youth will be provided with hygiene products, undergarments, and clothing that affirms their actual or perceived sexual orientation, gender identity, or gender expression.

During the review period, the agency did not have any SOGIE youth on their roster for review. While completing the walk-through, it was identified that the agency is complying with required postings. There are signs posted in every section of the shelter where the youth reside and in visitor areas, including the lobby.

There were no exceptions to this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The residential shelter is located at the agency's Tiger Bay facility. The shelter is co-located with other programs run by the agency. All youth furnishings and sleeping rooms were in good 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 six 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 providing a clean, healthy, and safe shelter environment. The policy has an effective date of July 1995, the policy was reviewed by Director of Adolescent Residential Programs on September 10th, 2018.

The shelter shall remain in good repair and maintained to include the inside and outside of the building, grounds, and equipment. The furniture within 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. Safe sleeping quarters will be provided as part of residential services, which include adequate lighting, bed coverings and pillows, windows, vents, and sprinkler heads free from covers, wire mesh, cardboard, etc.

The shelter has continued to maintain the cleanliness and orderliness of their current facilities. There was no evidence of damages to the building, the grounds, and no graffiti was observed in any areas around the building, nor on any of the furniture. The overall assessment of the grounds and facility was that it was extremely clean and very safe and secure.

All areas of the shelter were notated on the maps of the facility that were strategically placed around the building. The evacuation plan was present with these maps as well. The youth safety line number was posted in multiple places as well as identified within the youth orientation booklets. Also, all of the youth had access to grievance forms and the grievance policy. All of the youth's daily schedules and activities were posted in multiple areas around the building and meets all of the contractual requirements of physical activity, reading time, and faith based activity.

The annual fire inspection was completed on 11/1/2017, and the health inspection was completed on 7/11/2018. All of the facilities sprinklers and safety devices were in good working order. These documents, along with their valid DCF license were reviewed.

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 where each youth will be provided with an orientation into the program within 24 hours. The policy has an effective date of July 1995, the policy was reviewed by Director of Adolescent Residential Programs on September 10th, 2018.

The orientation shall first and foremost include a sincere welcome to BEACH House. A tour of the shelter, a Client & Family Rights &

Responsibilities booklet, and an orientation booklet outlining the following topics is included within 24 hours of admission into the program:

- Staff and peer introductions
- Fire exits/extinguishers and evacuation procedures
- Contraband list
- Program Schedule
- Dress Code
- Abuse hotline phone number
- Room assignment
- Behavior management system
- Visitation schedule.
- Telephone procedure
- Correspondence procedure
- Room assignment
- Behavior management system, including all rules and consequences.

There were six files reviewed, three open and three closed. All youth received on orientation to the program on the same day as admission. The youth were introduced to the Client handbook, Behavior Management System, Grievance process, Emergency plans, and facility layout. All this information was signed and agreed upon by the youth and staff.

During this review, it was observed that the agency policy states that Beach House is not a staff secured provider, however, all FI Network residential providers have to be available to provide staff secured services. However, while onsite the agency did revise the policy to address this and provided a copy of the newly approved policy to the reviewer.

There were no exceptions noted for this indicator.

3.03 Youth Room Assignment

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a policy in place for Youth Room Assignment. The policy has an effective date of July 1995. The policy was reviewed by the Director of Adolescent Residential Programs on September 10th, 2018.

Every client is interviewed to determine the most appropriate sleeping arrangement upon admission. Staff will utilize the CINS/FINS Intake Assessment form to assist with the youth classification. Bed assignments will be made according to a level based priority system (aggression level, physical characteristics, admission status, gang affiliation, past history of aggression, maturity, any physical illness, or self-harm potential).

All youth determined to be a risk of self harm or harm against others, will be placed in the observation room in order for staff to provide closer monitoring. All decisions of classification must be documented in the youth's chart in the SAN's note as to the reason for the decision. All suicide risk, mental health, physical health, or medical issues will be notated on the youth alert board.

There were six files reviewed, three open and three closed. All six files had the CINS/FINS Intake form completed at intake 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 harm themselves or others and that they would talk to a staff if needed. All this documentation is reviewed and signed by the youth, staff working with he youth, 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. The policy has an effective date of July 1995, and was reviewed by the Director of Adolescent Residential Programs on September 10th, 2018.

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.

Log books for the past six months were reviewed. All logbooks were orderly and neat. All entries were legible with a signature or initials at the end of each line. Shift reviews were conducted at the beginning of each shift and documented a review of the previous shift, as well as, a youth. A supervisor reviews the logbook on a regular bases and that review is highlighted through out the logbook. Camera system reviews are 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. The policy has an effective date of July 1999 and was reviewed by the Director of Adolescent Residential Programs on September 10th, 2018.

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. Staff training files reviewed 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. The policy was reviewed by Director of Adolescent Residential Programs on September 10th, 2018.

Beach House will staff each shift as follows:

There will be one staff member on duty for every 6 youth in the shelter from 7am to 11pm. There will be one staff member for every 12 youth in the shelter from 11pm to 7am. Every effort will be mad to have at least 2 staff members on the midnight shift.

The schedule will be posted for daily view. Beach house will make every effort to provide a male and female staff for each shift when there are both in the building. Staff is required to maintain a count of all youth at all times to ensure they know the whereabouts of the youth. All of the youth are accounted for on the white board and staff overnight checks (915 minutes) are completed by marking the Special Precautions FLOW Sheet.

The program's policy meets the staffing requirement of the Florida Network. Minimum staffing ratios were met after reviewing the previous 6 months of staff schedules and youth census rosters. All of the program staff schedules are posted on the door to the medication room, very visible and accessible. There is also a binder that holds all of the contact information for the staff that are considered on-call. All of the cameras are functioning and the 15 minute checks are being completed on the youth consistently.

Not employing more than one staff on overnight. It is not consistently happening, but it has happened multiple 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 that was last reviewed by the Director of Adolescent Residential Services on September 10, 2018.

The agency has a procedure for special populations including Domestic Minor Sex Trafficking, Domestic Violence Respite, and Probation Respite. The agency has specific criteria for each special population that aligns with the Florida Network requirements. The agency does not have procedures in place detail for youth served under Staff Secure.

There were six Residential files reviewed, three Domestic Violence Respite (DV) and three Probation Respite. According to the agency, there were no youth served that were considered Staff Secure or Domestic Minor Sex Trafficking.

There were no exceptions noted for this indicator.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for the Video Surveillance System. The policy was reviewed by Director of Adolescent Residential Programs on September 10th, 2018.

The agency's policy requires them to have a twenty four hour, seven days a week monitoring system. The system needs to retain at least thirty days worth of video or images, record date and time, have back up capabilities, have a list of authorized users, have a written notice in plain sight, and be reviewed by supervisors in the log book.

The shelter has a camera system that holds video for forty-five days and cameras images 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. A list of designated personnel was provided of individuals who have access to review the cameras.

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 policy for Healthcare Admission Screening. The policy has an effective date of 07/1995. The Director of Adolescent Residential Services reviewed the policy on September 10, 2018.

A Health History 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 the medication, the dosage and frequency of 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.

Parents will be notified for any youth determined to have physical health problems through the health screening. Staff will encourage parent/legal guardian to seek medical advice for a youth not being followed by a physician for a health issue.

There were seven youth files reviewed. All seven files documented the CINS/FINS Intake form and a Health History Questionnaire form was completed at intake. The Registered Nurse (RN) reviewed all Health History Questionnaires within five working days. All allergies, medications, substance abuse or mental health diagnoses were appropriately documented throughout all seven files. A body chart was also completed in each file that documented any scars, tattoos, or skin markings. An intake note was completed in each file that documented all information obtain from the intake screenings and interviews. There are procedures in place to involve the youth's parent or guardian if follow-up medical appointments are needed.

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. The policy has an effective date of 07/1995. The Director of Adolescent Services reviewed the policy on September 10, 2018.

Staff will use the CINS/FINS Intake form to screen for suicidal risk. If the youth answers "yes" to any of the six questions an assessment of suicide risk must be completed by a licensed mental health professional or an unlicensed mental health professional under the supervision of a licensed mental health professional. The assessment will occur no later than twenty-four hours after the screening unless the screening occurs between 5pm on Friday and 9am on Monday and there is no access to staff to conduct an assessment within twenty-four hours. The assessment must be completed by the morning of the first business day.

Youth awaiting an assessment will be placed on Constant Sight and Sound Supervision. If at any time during the screening any staff observes or believes a youth presents as an immediate threat to themselves or others, the youth will be placed on One-to-One Supervision.

The agency uses two levels of supervision. The first level is Constant Sight and Sound Supervision. This level is for youth who are identified as being at risk of suicide but are not expressing current Suicidal thoughts or threats. The second level of supervision is One-to-One Supervision. This is the most intense level of supervision and will be used while waiting for the removal of the youth from the program by law enforcement of parent/legal guardian for the purpose of Baker Act assessment.

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 youth were placed on constant sight and sound supervision until a suicide risk assessment could be completed. All three files documented the assessment was completed by the LMHC within twenty-four hours. All three youth were removed from suicide precautions and placed on normal supervision. There were thirty-minute observations of the youth the entire time the youth were on constant sight and sound supervision. There was documentation found in the logbook for all three instances reviewed.

There were no exceptions to this indicator.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Medications. The policy has an effective date of 07/1995 and was last reviewed on September 10, 2018 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 Registered Nurse's (RN) who are responsible for both programs located on the same campus. There is always at least one RN on-site Monday through Friday from approximately 6am to 3:30pm. The RN will distribute all medications when on-site.

The agency provided a list of nine staff who are trained to supervise the self-administration of medications. There are five Super Users listed, including both RN's, both Operation Specialists, and a Residential Shift Manager.

The RN trains 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. The RN also completes remedial training with staff when needed for medication errors or discrepancies.

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. Medications are verified at admission using one of the four approved methods by the Florida Network.

There have been sixteen discrepancies in the last thirty days. All discrepancies involved inaccurate counts and were easily fixed. Discrepancies were generally closed out by the end of the staff members shift.

Trained direct care staff complete an inventory every shift of all the controlled substances. This inventory is documented on the Narcotic/Controlled Substance Count Sheet and also in the logbook highlighted in yellow. 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 does a weekly inventory of all medications in the Pyxis Med-Station.

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 thermometer is located in the refrigerator and documented a temperature of 36 degrees. The Operations Specialist checks the thermometer at least once a week and documents the temperature.

The shelter has four different sharps located in the facility, including three knife-for-life's, two pill cutters, one pair of scissors, and one wire cutter. These sharps were inventoried each week for the past six months.

The shelter has four OTC's: Tums, Tylenol, Pepto-Bismol, and Allergy Relief. There was documentation these OTC's were inventoried weekly for the last six months.

The RN is utilizing the Knowledge Portal and running various monthly reports.

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 five days remaining and request them to bring in a refill. The shelter has disposal procedures in place for medication that is left at the facility after requests have been made for the parent or guardian to pick up the medication.

There were five youth in the shelter currently on medications. There was documentation that all the medications were verified at admission. The Medication Distribution Record (MDR) is maintained in a binder in the staff work area.

All the MDR's 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, method of administration, and the full printed name, signature, and initials 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 MDR's reviewed on site document that perpetual inventory counts with running balances are being maintained on each medication. All MDR's 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 six CCC reports in the last six months relating to medication errors. The errors were related to youth not receiving prescribed medication at the appropriate times. These errors generally occurred during hours the RNs were not on-site, and staff were responsible for distributing the medication. There was documentation in these instances of staff receiving verbal and written reprimands and also receiving remedial training on the medication administration process. All instances documented a pharmacist was notified and none of the youth suffered any adverse reactions due to the errors.

There were no exceptions to this indicator.

4.04 Medical/Mental Health Alert Process

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a policy on the Medical and Mental Health Alert Process. This policy was effective 07/1995 and last reviewed on September 10, 2018 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' office and is concealed from plain view. 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 alert; 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; light green for no razors; 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 seven 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. There was 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, inside the youth's file. All alerts were also appropriately documented on the large dry erase board in the Youth Specialists' office.

There were no exceptions to this indicator.

4.05 Episodic/Emergency Care

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a written policy on Episodic/Emergency Care. This policy was effective in 10/1998 and was last reviewed on September 10, 2018 by the Director of Adolescent Residential 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 office, 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.

The shelter has four first aid kits located throughout the facility. There was documentation these first aid kits were checked monthly by the RN for expired items and replenished as needed. The agency also maintains first aid kits in each of the three vehicles. A review of these kits revealed expired contents. An interview with the RN revealed these kits are not included in the monthly check of the other first aid kits. A knife for life and a pair of wire cutters are maintained on a shadow board in the medication room.

The shelter has not had any off-site emergency/episodic care events in the last six months. The shelter conducted seven medical emergency drills in the last six months, on various shifts.

There were no exceptions to this indicator.