



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

Review of CDS-Interface Central

on 05/11/2016

## CINS/FINS Rating Profile

### Standard 1: Management Accountability

1.01 Background Screening	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	Limited
1.07 Outreach Services	No rating

Percent of indicators rated Satisfactory: 66.67%  
Percent of indicators rated Limited: 33.33%  
Percent of indicators rated Failed: 0.00%

### Standard 2: Intervention and Case Management

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

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

### Standard 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	Limited
3.07 Special Populations	Satisfactory

Percent of indicators rated Satisfactory: 85.71%  
Percent of indicators rated Limited: 14.29%  
Percent of indicators rated Failed: 0.00%

### Standard 4: Mental Health/Health Services

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

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

## Overall Rating Summary

Percent of indicators rated Satisfactory: 84.00%  
Percent of indicators rated Limited: 16.00%  
Percent of indicators rated Failed: 0.00%

### Rating Definitions

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

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
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.

### Review Team

#### Members

- Ashley Davies, Lead Reviewer and Consultant, Forefront LLC
- Bruce Morton, Program Monitor, Department of Juvenile Justice
- Danielle Husband, Program Director, Youth and Family Alternatives

Teresa Clove, Executive Director, Thaise Educational

Leah Saker, Treatment Counselor, Hillsborough County Children's Services

**Persons Interviewed**

- |  |                          |                         |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 1 Case Managers          | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor                 | 1 Clinical Staff         | 1 Program Supervisors   |
| <input type="checkbox"/> DHA or designee             | 0 Food Service Personnel | 0 Other                 |
| <input type="checkbox"/> DMHA or designee            | 1 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 type="checkbox"/> Confinement Reports                          | <input checked="" type="checkbox"/> Logbooks                         | 5 Health Records   |
| <input 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 type="checkbox"/> PAR Reports                                 | 11 Personnel Records   |
| <input type="checkbox"/> Contract Scope of Services                   | <input checked="" type="checkbox"/> Precautionary Observation Logs   | 8 Training Records/CORE  |
| <input checked="" type="checkbox"/> Egress Plans                      | <input checked="" type="checkbox"/> Program Schedules                | 4 Youth Records (Closed)                                       |
| <input type="checkbox"/> Escape Notification/Logs                     | <input type="checkbox"/> Sick Call Logs                              | 4 Youth Records (Open)   |
| <input checked="" type="checkbox"/> Exposure Control Plan             | <input type="checkbox"/> Supplemental Contracts                      | 0 Other  |
| <input checked="" type="checkbox"/> Fire Drill Log                    | <input checked="" type="checkbox"/> Table of Organization            |  |
| <input checked="" type="checkbox"/> Fire Inspection Report            | <input type="checkbox"/> Telephone Logs                              |  |

**Surveys**

- |         |                     |         |
|---------|---------------------|---------|
| 6 Youth | 6 Direct Care Staff | 0 Other |
|---------|---------------------|---------|

**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"/> Medical Clinic            | <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

Since the last on-site quality improvement review a Residential Counselor transferred to the Non-Residential Program. And three out of five Non-Residential Counselors are Licensed Mental Health Counselor's (LMHC).

The shelter partnered with the University of Florida. They came in to redesign the whole lobby area of the facility. It was painted and a children's area was added for younger youth.

In October the shelter received the contract for the SNAP Program. Groups started in January with seven families. All seven families attended all thirteen sessions.

The shelter hired a new Residential Counselor to replace the one transferred to the Non-Residential Program.

A shelter counselor developed a "home system" component of the Behavior Management System for parents to take home and utilize in the home environment.

The shelter has continued to focus on involving the youth in the program to increase their longevity in the program. They have focused on teaching the youth how they can benefit from the program. The youth receive recognition at 8, 21, and 35 days.

## Standard 1: Management Accountability

### Overview

#### Narrative

CDS Family and Behavioral Health Services, Inc. – Interface Youth Program Central provides both residential and non-residential programs. This program site is located in Gainesville, Florida. The CDS-Central program provides services through a direct local service provider contract with the Florida Network of Youth and Family Services (FNYFS). The CDS-Central agency primarily provides CINS/FINS services in Alachua, Gilchrist and Levy Counties. CDS-Central also operates sister Residential and Non-Residential programs in Lake City and Palatka, Florida respectively. All three CINS/FINS program locations report to the agency’s Chief Executive Officer and Chief Operations Officer that are located in the headquarters office in Gainesville, Florida.

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 protocols 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 and 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

A review of eleven staff hired since the last quality improvement review found each of the staff had been background screened through the Department of Juvenile Justice Background Screening Unit (BSU) prior to their date of hire. There were no staff due for a five year re-screening during the review period. There was documentation of completion of the Annual Affidavit of Compliance with Level 2 Screening Standards in January 8, 2016.

There were no exceptions to this indicator.

### 1.02 Provision of an Abuse Free Environment

Satisfactory                       Limited                       Failed

#### Rating Narrative

A review of the policy for Abuse Free Environment covered staff conduct and youth access to the Florida Abuse Hotline. Interviews with staff indicated a strong commitment to provide youth in the shelter with the best available services to address professional behavior of the staff, the youth’s current (personal, family, and educational)

situation, and to facilitate a positive relationship between the youth and their families. A review of six staff and six youth surveys found no report of unprofessional behavior by the staff. Each of the six staff and five of the six youth knew how to access the Florida Abuse Hotline. All of the six youth reported that they have not needed to call the abuse hotline while in the shelter.

There were no exceptions to this indicator.

### 1.03 Incident Reporting

Satisfactory                       Limited                       Failed

Rating Narrative

A review of Central Communication Center (CCC) reports was conducted and twelve were found for the last six months. In all reports, the CCC was contacted within two hours of the program learning of the incidents. All reports were documented in the program log and on incident reporting forms. The reports were successfully closed out with all supporting documentation in the file.

There were no exceptions for this indicator.

### 1.04 Training Requirements

Satisfactory                       Limited                       Failed

Rating Narrative

A review of three first-year training files found each of the staff had completed at least eighty hours of training within the first year of employment with the program. However, none of the staff had documentation of completing program orientation, two of the three staff did not have documentation of completing training on Title-IV Procedures, one staff did not have documentation of completing training on CINS/FINS CORE, two staff did not have documentation of completing training on suicide precautions, none of the staff had completed training on fire safety equipment, one staff did not complete training on First Aid, none of the staff had completed training on universal precautions/blood borne pathogens, and only one staff had completed training on the signs and symptoms of mental health and substance abuse.

A review of five in-services training files found that all of the staff had documentation exceeding the required twenty-four hours of annual training. However, none of the staff had documentation of completing training on suicide precautions or fire safety equipment. One staff did not have documentation of a current First Aid certificate.

Exceptions:

A review of staff training files revealed staff were missing numerous required first-year and in-service trainings.

### 1.05 Analyzing and Reporting Information

Satisfactory                       Limited                       Failed

Rating Narrative

The parent company compiles monthly outcome data reports that cover all of their programs by funding source and personnel. An interview with a CDS Regional Coordinator indicated that they produce monthly and bi-annual outcome reports and that Corrective Action Plans (CAP) are generated to address any deficiencies that were identified from these reports. The reports address information from NetMIS and other data sources within CDS that included the following: monthly staff and unit performance and projections, missing youth documents, the number of 30 and 60-day follow-ups: (late, early, and current), current number of monthly youth screenings, number of drills conducted each month, number of youth admitted and discharged from their programs, the number of youth served requiring emergency shelter placement, the number of youth active longer than 12 weeks, medical emergencies,

internal personnel and DJJ (CCC) incident summaries, and current staff caseloads. The report is also broken down to address individual staff performance in monthly and YTD increments. The report identified program performance projections needed to meet contractual requirements.

There were no exceptions to this indicator.

### 1.06 Client Transportation

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has an updated transportation policy as of December 2015 which indicates youth transports must include a 3rd party and if a 3rd party is not available or possible, then the youth's history and behavior as well as the driver's history and work performance is considered and supervisory approval, prior to transport, is required and documented accordingly. As of December 2015, the agency made a change to their log books to include a separate entry area to account for transportation of the youth and indicate whether or not the agency was conducting a single youth/staff transport. There was not a specific list of approved drivers but the agency does advise employees that they are not eligible to drive for the agency.

In reviewing the log book transportation entries from December 5, 2015 through May 12, 2016, there were twenty-one documented instances where the supervisory approval was not documented for single client transports.

It was also noted in the Blue IYP-C Transport Van Log, May 2 - 12, 2016, there were five documented instances of a youth being alone in the vehicle with an adult on the Travel/Van Log but the documentation on the Log did not match the documentation in the program log book. The program log book did not indicate there was a single client transport or that supervisory approval was obtained.

Exceptions:

There were twenty-one instances in the last five months where supervisory approval was not documented for single client transports. In addition, there were five documented instances of a youth being alone in the vehicle with an adult on the Travel/Van Log but the documentation on the Log did not match the documentation in the program log book. The program log book did not indicate there was a single client transport or that supervisory approval was obtained.

### 1.07 Outreach Services

Satisfactory

Limited

Failed

#### Rating Narrative

The agency maintains a binder with up-to-date Cooperative Service Agreements with many community stakeholders and partners. A large majority of them were updated in 2015 and are in effect until June 2017.

The agency has a policy related to the roles and responsibilities for the Prevention Outreach efforts and they maintain an Outreach Plan for targeting youth. Both of these policies were last updated in September 2015.

The agency's CEO is the Chair for the Circuit 8 DJJ Advisory Board and documentation was provided that he attended meetings in February and May 2015 and January and March 2016.

A staff member attends the Alachua County Juvenile Justice Council and provided an attendance record of attending seven provider meetings during this fiscal year.

The agency also maintains a binder with a monthly newspaper article about CDS and the impact of the agency in the community.



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 five Non-Residential Counselors; three of which are Licensed Mental Health Counselors (LMHC), one holds a Ph.D., and one is a Master’s level counselor. All Family Action Staff members and residential counseling staff members have access to the agency’s Chief Operation Officer who is a Licensed Mental Health Clinician. The screening determines eligible youth and family whom are referred to the respective residential or non-residential 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 Staffing’s, 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

There were eight files reviewed—four residential and four non-residential. The agency has a central intake service available twenty-four hours a day through the shelter for the residential and non-residential programs. The initial screenings were consistently being completed within seven calendars days of the referral. During the intake process the parent and child are receiving available service options and are given the Participant Orientation Packet which includes the Grievance Procedures and the Client Rights and Responsibilities. The Parents signed all forms with the youth having the option to sign. It is clearly stated on the Consent Form that if the youth is under eighteen he/she has an option to sign or not.

There were no exceptions to this indicator.

### 2.02 Needs Assessment

Satisfactory
  Limited
  Failed

Rating Narrative

There were eight files reviewed—four residential and four non-residential. The Needs Assessments were consistently being completed within two to three face-to-face contacts and within 72 hours of admission for both the residential and the non-residential programs. All staff are either a Bachelor’s level, Master’s level, or PHD level counselor. A license professional is reviewing and signing off on the Needs Assessment within one to five days after the counselor completes them.

There were no exceptions to this indicator.

### 2.03 Case/Service Plan

Satisfactory
  Limited
  Failed

Rating Narrative

There were eight files reviewed—four residential and four non-residential.

The Case Service Plans were consistently being completed within seven working days following the completion of the Needs Assessment. All eight files reviewed addressed the identified needs of the youth. All files included the type, frequency, location, person responsible, signature of the youth, parent, counselor and supervisor. One residential case file did not have the target date for completion listed on the Individualized Service Plan and one non-residential file did not have the beginning date on the Individualized Service Plan. The four residential files were discharged before the thirty day Service Plan Review. The four non-residential Service Plan Reviews were all completed in the time frame.

Exceptions:

One residential case file did not have the target date for completion listed on the Individualized Service Plan and one non-residential file did not have the beginning date on the Individualized Service Plan.

**2.04 Case Management and Service Delivery**

Satisfactory                       Limited                       Failed

Rating Narrative

There were eight files reviewed—four residential and four non-residential.

Each of the youth were assigned a counselor after entering the residential and non-residential programs. The name of the counselor was listed on the Service Plan and throughout the file. The counselor implemented a Service Plan based on the youth's needs and met with the youth and their parent regularly. Some families were referred to other agencies based on their need after discharge.

There were no exceptions to this indicator.

**2.05 Counseling Services**

Satisfactory                       Limited                       Failed

Rating Narrative

There were eight files reviewed—four residential and four non-residential. All eight files indicated that all the youth and their families are receiving counseling throughout the time they are in the shelter and in the non-residential program. The shelter provides group, individual, and family counseling, while the non-residential program provides individual and family counseling. Each program maintained individual case files—case notes were chronologically filed and all files had "Confidentiality" stamped on the front of the file. The supervisor reviewed the case files and signed off on the reviews as required.

There were no exceptions to this indicator.

**2.06 Adjudication/Petition Process**

Satisfactory                       Limited                       Failed

Rating Narrative

The agency has not had any Case Staffings since the last on-site quality improvement review. However, there is a process in place if needed. The Case Staffing Committee meets the third Tuesday of each month if there are cases that need to be staffed or reviewed. The committee also meets to discuss the Case Staffing process when requested or needed.

There were no exceptions to this indicator.

### 2.07 Youth Records

Satisfactory

Limited

Failed

#### Rating Narrative

There were eight files reviewed—four residential and four non-residential. All eight files were marked confidential. The files are located in the Data Clerk's office and the door remains locked at all times. The files are stored in locked file cabinets. When files are being transported they are transported in a locked, black, opaque file container marked confidential. The case files are legible, neat and orderly, and divided into sections.

There were no exceptions to this indicator.

## 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 twelve 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, and a smaller meeting room, multi-purpose 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, twenty-four 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 Environment

Satisfactory

Limited

Failed

#### Rating Narrative

There was documentation of an annual Fire Safety Inspection.

Documentation of annual fire safety equipment inspections were valid and up-to-date. Fire extinguishers were located throughout the facility and were last inspected in February 2016.

Fire Drills were completed monthly on each shift; however, there were noted omissions such as duration of the drill, dates and times, and number of clients and adults.

There was evidence that the agency had a current Satisfactory RGC inspection report from the Department of Health dated October 26, 2015.

The agency had evidence of a Satisfactory Food Service inspection report. The food menus were posted in the dining area and run on a twelve week cycle. The Licensed Dietician signed off on each menu on June 8, 2015.

The DCF Child Care License certificate was located in the waiting room dated April 1, 2016.

There was evidence of detailed maps of the agency located throughout dwelling. In each of the living areas (males/females) general client rules, hotline information and number were posted on the bulletin boards. There were also locked grievance boxes and forms for the youth to fill out. The agency also utilize a Glad Mad Sad Log that the clients can submit to express their feelings.

The agency has surveillance cameras that appeared to be operational as witnessed in the control room. It was

reported that the agency maintains the recordings for thirty days.

The interior areas were clean and free of insect infestation. There was documentation of monthly pest control services.

The agency is located in an older dwelling. The furniture appears to be in good order. There was however evidence of some graffiti in the bedroom areas (bunk bed frame, mattress). There was no evidence of contraband or hazardous/unauthorized material.

The bathrooms appeared clean, did not have any leaks of mold and had operational hand dryers.

There were two dryers and one washing machine. There was a build-up of lint located in one of the dryers. The second dryer which was recently used (evidence of dried clothing and during first walk through was running) had lint. The washer had newly washed clothing. It was reported that the staff launder the clients clothing.

There was evidence of a daily activities schedule located in the daily living rooms and dining area. The schedule offered meal times, social, recreational and educational activities as well as life skills groups and time for meeting with their counselors. Though not listed on the schedule it was reported that the clients have the opportunity to engage in faith based services off campus on a weekly basis and each Thursday they have a volunteer who conducts a non-denominational "Hear Hope" group for the youth.

Exceptions:

One dryer had lint build-up that was cleaned out while on-site. There was some graffiti observed in the bedroom areas.

### 3.02 Program Orientation

Satisfactory

Limited

Failed

#### Rating Narrative

There were five youth files reviewed: two open and three closed. Each file contained an Orientation Checklist that included youth and staff signatures. The youth initialed the components of the program to include the grievance procedure, a tour, emergency evacuation procedures, visitation, and the Behavior Management System. They are also provided with a Participant Orientation Packet. The parent/guardian was a part of the intake process and signed necessary paperwork.

The orientation checklists indicated that the rules on contraband are reviewed. However, the Participant Orientation Packet does not specifically identify what constitutes contraband. There is evidence of a list of contraband posted at the main entrance of the facility.

There were no exceptions to this indicator.

### 3.03 Youth Room Assignment

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has designated male and female living and bedroom areas connected by the staff office. Each bedroom has five bunk beds and two single beds available. There is an Achievement Room that the shelter can utilize to place one youth if they needed to be separated due to identified risk factors.

In the five youth files reviewed there was documentation that key indicators include: age, birth gender, physical size/strength, suicide risk, disabilities etc. and are identified in the room assignment assessment. However, there was no indication that the youth's gender identification was addressed or documented.

All the files reviewed had Special Bed Assignment checked off as "None." However, there was one male youth that had a pending Sexual Assault charge. The agency reported they have served this youth in the program before and did not identify him as needing a specific bed assignment nor were any safety precautions needed.

Exception:

The youth's bed assignment does not include the youth's gender identification.

### 3.04 Log Books

Satisfactory

Limited

Failed

#### Rating Narrative

Log books were reviewed for a six month period (November 2015 – current). The agency utilizes a costumed made pre-printed bound log sheets with designated places for the staff to enter the date, circle the day of the week, and the assigned Shift Leader. There is also a designated spot for the Key Holder Exchange for the name of the staff from the previous shift and for the current shift. In addition there are designated spots for the staff to sign, as well as, who the staff would be to ensure medication administration and, if needed, Staff Secure staff. There is also a designated location for the client (participant) name and boxes for one formal count and two informal counts, as well as, the status of the client (in house, out of house), as well as, the time and staff initials. The log book also has a section for the Shift Leader to document their review of the previous shifts. They are to put the dates that they reviewed and sign and date when they reviewed. There are sections identified for passing on information and chronological shift events (Shift Leader Summary) as well as Shift Leaders Comments. There is a reminder statement asking if the Shift Leaders assignments were completed, as well as, a spot for the Shift Leader to sign and date that they reviewed the documentation at the end of the shift.

The staff entries in the log book are written in ink and for the most part easily legible. The books contained documentation that safety and security issues, as well as, incidents were documented as appropriate. Client counts were documented three times per shift (day, evening and night) indicating the status of the clients current location. Entries were evident when clients were on visits. For the most part there were weekly signed entries by the Residential Supervisor indicating that he reviewed the log book pages. However, there was no indication of feedback provided to the staff.

There were noted instances where Shift Leader did not always provide a signature after making entries in the Shift Leader Comment Section. Documentation was evident that the Shift Leaders generally reviewed the previous shift notes. However, there was no indication that direct care staff reviewed the previous two shifts. There were instances of blank lines that were not marked through to prevent additional entries after the fact.

Exceptions:

There was no documentation direct care staff were reviewing the previous two shifts. There were instances of blank lines that were not marked through to prevent additional entries after the fact.

### 3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

#### Rating Narrative

The agency uses the "Face Book" program as part of their Behavior Management and the program is discussed upon intake with the youth. CDS also works to discuss the program with families and encourages them to follow a modified version of the program at home with the youth after discharge.

The "Face Book" program has three sections and as youth progress through the sections they are able to earn

special privileges.

It was noted that of eight closed files reviewed for the "Face Book" book, seven of the files did not include the youth's signature that he or she had the program explained at the time of intake. However, there is evidence in all eight of the "Face Books" that the point system was being used on a daily basis.

CDS offers a grievance process to provide the youth with the ability to express their concerns about the program. The program also offers the youth a Glad Mad Sad Log as an additional opportunity to provide feedback about the program and the services they are being offered.

In reviewing the Seclusion and Restraint and Aggression Control Policy (last updated in January 2015 and approved by the COO on January 20, 2015) the policy indicates staff will use verbal de-escalation techniques and emergency crisis intervention techniques to manage aggression from a youth and maintain a safe environment. A review of five training files indicated three out of five employees did not receive training on crisis intervention techniques. Regarding the Behavior Management Strategies, five out of five employees had a training related to Behavior Management.

Evidence of training on the "Face Book" program was not present in all of the employee files. However, in five of the files there was a sheet which indicated training on "Face Book" needed to be completed. There was no evidence in any of the five files that the employee had received the training as required. One of the five files did contain a supervisory signature on May 11, 2016 but did not include the employee signature that the training had been completed. The other four files did not contain an employee or supervisory signature for the required training.

Exception:

In the five staff training files reviewed there was documentation the staff had received Behavior Management training. However, there was no documentation the staff received training on "Face Book", the shelters specific Behavior Management Program.

### 3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

#### Rating Narrative

CDS maintains a Master Shift Schedule and works to maintain the required staffing ratios. The agency follows the staffing ratio of one staff to six youth during awake hours and one staff to twelve youth during sleeping hours, but will always maintain at least two staff on the overnight shift.

The agency attempts to have a male and female staff member on each shift, daily. However, the agency also acknowledges some difficulty in hiring male staff. The agency actively works to hire more male staff and has on-going recruitments posted on two different internet sites and on their Facebook page. The Residential Supervisor is aware of the agency policy and expectations around staffing and works to meet all required staffing patterns.

The staff schedule is updated to accommodate for call-offs and time off requests and the Residential Supervisor works to ensure all shifts are covered as needed.

The agency maintains a recall roster and in addition to full-time and part-time staff they maintain some PRN staff to assist in the event of a call-off or unforeseen situation.

The agency utilizes an electronic bed check monitoring system which requires the employee to scan a bar code outside of the youth bed room and within the youth bed room to have the bed check registered as completed. Video recording is also used in the male and female living rooms within the dorm area.

A random review of video footage from three separate evenings from April 2015 showed staff completing the bed check process. The current camera system does not include footage of the staff members when they are in the "master control" area and does not include footage of the actual youth bed rooms.



It was noted on April 10, 2016 that the male employee left the boys dorm area unattended, on more than one occasion, for up to approximately twenty minutes at a time.

In reviewing the printed bed check logs, the bed checks were usually being completed within 10-20 minute intervals. However, it was noted there were multiple occasions where the time span between bed checks were over twenty minutes, and being conducted up to forty-five minutes after the prior bed check was completed without documentation in the program log book to explain the lag in the bed check. The lag time between bed checks (twenty minutes or more) was noted to occur almost nightly in the boy's dorm, and many times on more than one occasion in the same evening and less frequently in the girl's dorm. During a review of video footage on April 24, 2016, there was a bed check lag from 2:37AM until 3:07AM and the video footage revealed the employee sitting in the living room area and appearing to be attending to personal matters (cell phone and lap top computer) during this period of time.

Exception:

There were numerous occasions observed where bed checks exceed the fifteen minute requirement. This occurred almost nightly during a six month period and several times throughout the night.

### 3.07 Special Populations

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has policies and procedures for Staff Secure Shelter, Domestic Minor Sex Trafficking, Domestic Violence Respite, and Probation Respite.

Three youth files were reviewed for Domestic Violence Respite (DVR). All youth that were placed in the shelter for DVR had a pending DV Charge and had a referral sent from the Florida Department of Juvenile Justice for shelter placement. None of the youth extended their stay of the twenty-one day maximum DV respite stay. The Service Plans reflect goals addressing the youth reason for referral on two of the cases. One youth's respite stay was only three days which did not allow the counselor enough time to complete a Service Plan. That youth was released to his father after being discharged from the shelter.

There were no instances of Staff Secure, Domestic Minor Sex Trafficking, Domestic Violence Respite, or Probation Respite services since the last on-site review.

There were 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 Chief Operation Officer (COO) is a Licensed Mental Health Counselor.

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 four 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 utilizes policy P-1117 to address screening for all past or current medical conditions. The policies state each youth will be provided a preliminary physical health screening and also staff will 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. Once the intake process is complete, the intake staff and supervisor will review the packet. The youth's guardian will be interviewed about the youth's current medications. This process will be conducted by a Registered Nurse if one is on the premises. Otherwise, this interview will be conducted by the on-duty staff and reviewed by the Registered Nurse within 72 hours.

A total of five files 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. The agency also captured additional health screening information on a "Screening Health Addendum". This form captures whether the youth is eligible to receive services and screens for any yes response to six health related questions. These questions ask the youth "In the last 48 hours have you experienced any Fever; Diarrhea; Vomiting; Sore Throat; Continuous coughing and/or sneezing; and cold like symptoms". All five files reviewed also contained this form completed. None of the youth required any follow-up medical care; however, there are procedures in place if it is needed. Once the intake process is complete, the intake staff person and a supervisor or shift leader reviews the 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. Of the five files reviewed, four youth were on medication and the medications, as well as, the reasons for the medication were documented. There were two

youth with allergies and both files documented they were seasonal. There was one youth who had an allergy to milk and this was found documented throughout the youth's file along with a special diet plan which indicated the substitutions the youth would receive in the place of regular whole milk.

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 that include nine health issues.

There were no exceptions to this indicator.

#### 4.02 Suicide Prevention

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has policy on Suicide Assessment addressing the requirements of this indicator. 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 agency's CEO is a Licensed Mental Health Counselor (LMHC), as well as, four of the non-residential counselor's. The CEO or one of the non-residential counselors review suicide risk assessments completed at the shelter by unlicensed staff.

There were three youth files reviewed for youth who had been placed on suicide precautions (one open and two closed). All three youth were placed on suicide precautions at intake due to issues identified during the screening process. All youth remained on sight and sound supervision until assessed by a qualified professional. All youth were seen and assessed by a master's level counselor, using a suicide risk assessment, within twenty-four hours. All suicide risk assessments contained documentation of consultation with an LMHC. All risk assessments were faxed to the LMHC for review and signature. All youth were placed on normal supervision levels upon completion of the assessment. All three youth had thirty minute observations documented the entire time they were on suicide precautions. All suicide precaution events were documented in the logbook.

One of the three youth reviewed was also Baker Act during their stay in the shelter. The youth wrote a suicide letter and gave it to staff. Staff immediately placed the youth on one-to-one supervision and notified the counselor. The counselor completed a suicide risk assessment immediately and law enforcement was called to Baker Act the youth. Observations were documented until the youth left the shelter with a law enforcement officer.

There were no exceptions to this indicator.

#### 4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a very detailed policy on Medication Provision, Storage, Access, Inventory, and Disposal. The policy has detailed procedures for Prescription Medication, Verification of Medication, First Aid and Over-the-Counter Medication, Utilization of the Pyxis Med-Station 4000, Medication Provision, Supervision, and Monitoring, Medication Errors and Refusals, Medication Storage, Access to Medication, Inventory Procedures, Medication Counting Procedures, Discharge of Youth with Medication, and Disposal.

The shelter provided a list of 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, with one of those staff being the Registered Nurse (RN).

The shelter has hired a RN who has been employed at the shelter since February 2016. The RN is on-site seven days a week, totaling approximately twenty hours a week. The RN is on-site every evening and distributes evening medications, all other times trained staff dispense the medications. The RN does complete various different trainings with the staff, including medication administration. The shelter began using the Pyxis Med-Station at the end of March 2016. The RN reported most discrepancies produced by the Pyxis Med-Station were of staff having issues with inputting half pill counts. These discrepancies were easily fixed by the RN and at the time of the review the shelter had no open discrepancies.

All youth medication is stored in the Pyxis Med-Station. After the youth's information is entered into the Pyxis Med-Station, a bin within the machine is assigned to the youth. Each medication is stored in its own separate bin within the Med-Station so topical medications are always stored separately. The youth's medication is placed in that bin and once it is closed it can only be opened during assigned medication times or for inventory purposes. Staff using the Pyxis Med-Station have to enter a password as well as their finger print to gain access. 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.

All medications are inventoried at admission, when given, by maintaining a perpetual inventory with running balances and at discharge. All controlled medications are also inventoried each shift by two staff members. The inventories are documented on the back page of the youth's Medication Record Log (MRL). All non-controlled medications are inventoried at least once per week, by two staff members and also documented on the back page of the MRL. All sharps in the shelter are inventoried once per week. This documentation was reviewed for the last six months.

There were four youth files 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 is maintained in the youth's individual file. All MRL's 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.

In three of the four files reviewed all MRL's reviewed documented that perpetual inventory counts with running balances were being maintained on each youth. In three of the four files, MRL's reviewed for the youth also documented that all medications were given at prescribed times. In one file reviewed, there were seven different instances where this reviewer was unable to determine if the youth received the correct dosage of medication. The youth was to receive one pill in the morning and half a pill in the evening. During these seven instances the medication count was incorrect but it could not be determined if the error in the count was due to an incorrect inventory documented by the staff or if the youth did actually receive the wrong dosage, as the days were not consecutive days but were scattered across a three-week period. This was a closed file and the youth was no longer in the shelter to be interviewed. However, when the youth was discharged from the shelter the youth did leave with the correct amount of medication left, indicating at some point the error was corrected but not documented anywhere how it was corrected. It was also noted that the perpetual inventories on this medication

were not being documented, when the youth received the medication or this error would have been caught earlier on.

All inventories of medications on-site were completed as required—shift-to-shift for controlled medications and at least weekly for non-controlled medications and documentation on the MRL with two staff member's initials.

The shelter has had eight CCC reports relating to medication errors in the last six months. Seven of the eight errors were due to youth not receiving medication. One of the reports was due to a youth receiving two doses of their medication. Two of the reports reviewed for youth not receiving medications were for multiple days of missed medications. Five of the errors were in the last three months, with three of the five being in the last month. Although corrective action (in the form of a written memorandum placed in their personnel file) was documented in all the cases, there still seems to be an on-going concern of youth not receiving required medications. In addition, during the on-site review a CCC call was made by the program in regards to the previous mentioned file with the seven instances of incorrect doses (or inaccurate counts) of medication.

Exceptions:

The shelter has had eight CCC reports relating to medication errors in the last six months.

In one file reviewed, there were seven different instances where this reviewer was unable to determine if the youth received the correct dosage of medication. The youth was to receive one pill in the morning and half a pill in the evening. During these seven instances the medication count was incorrect but it could not be determined if the error in the count was due to an incorrect inventory documented by the staff or if the youth did actually receive the wrong dosage, as the days were not consecutive days but were scattered across a three-week period. This was a closed file and the youth was no longer in the shelter to be interviewed. However, when the youth was discharged from the shelter the youth did leave with the correct amount of medication left, indicating at some point the error was corrected but not documented anywhere how it was corrected. It was also noted that the perpetual inventories on this medication were not being documented, when the youth received the medication, or this error would have been caught earlier on. This incident was reported to the CCC while on-site. However, was not accepted as a reportable incident and documented as "information only".

#### 4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has a policy in place for the Medical and Mental Health Alert Process. 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 (MRL). Medication allergies, food allergies, and any other allergies are noted on the Intake/Assessment Form, the MRL, and on the spine of the youth's file with "Allergy" checked off and a "Medical/Mental Health Alert" label on the spine with "Allergy" checked there as well. In addition, youth issues, concerns, conditions, or physical restrictions are noted on the youth board in the staff office using appropriate codes. All incoming staff review the youth board beginning of each shift.

A review of five open youth files and two closed youth files was conducted to verify the shelters alert process. Six of the seven files documented any applicable alerts on the spine of the youth's file. However, one of the closed files had conflicting information on the spine of the file. The "Medical/Mental Health Alert" label on the file had "Allergy" appropriately checked off as required. However, next to "Allergy", on the spine label, "No" was circled. All medical related information was documented on the Intake/Assessment Form inside the file. One open file documented on the Intake/Assessment Form that the youth was allergic to penicillin. However, there was not an "Allergy" alert documented on the spine of the youth's file or on the alert board in the staff office. This alert was however documented on the youth's MRL and in the Pyxis Med-Station. The alerts and issues documented in the remaining four open files reviewed corresponded with alerts documented on the alert board in the staff office. Alerts on the board were coded with numbers 1-18, with each number representing a different alert. Staff interviewed were

knowledgeable of the alert system.

Exception:

One open file documented on the Intake/Assessment Form that the youth was allergic to penicillin. However, there was not an "Allergy" alert documented on the spine of the youth's file or on the alert board in the staff office.

#### 4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has an Emergency Care Policy in place. There are procedures in place for staff to follow in various different types of medical emergency situations.

There have been two off-site emergency care events in the last six months. One youth was taken off-site for fainting and another youth was taken off-site for taking a large dose of unknown tablets. Both cases contained documentation the youth's parent or guardian was notified and the incident was reported to the CCC. Both youth returned to the shelter with discharge instructions and those were documented as well. Both incidents were documented on the Daily Medical Log for Episodic/Emergency Care; however, only one of the incidents was documented in the shelter log book.

The shelter has completed a Medical Emergency Drill, on each shift, in the last quarter. The drills consisted of a bee sting, a fall, and a nose bleed.

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.

There were no exceptions to this indicator.