



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CDS-Interface Central

on 05/06/2015

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

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

Standard 3: Shelter Care

3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Special Populations	Satisfactory

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

Standard 2: Intervention and Case Management

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

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

Standard 4: Mental Health/Health Services

4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	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%

Overall Rating Summary

Percent of indicators rated Satisfactory:95.83%
Percent of indicators rated Limited:4.17%
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

Mike Marino, Regional Monitor, DJJ

Kori Drake, CINS/FINS Program Supervisor, Youth and Family Alternatives - Circuit 10

Tenia Rumph, Program Director, Family Resources - Manatee

Janet Valdez, Program Supervisor, CHS Osceola

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 2 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 2 Clinical Staff | 2 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 1 Food Service Personnel | 0 Other |
| <input type="checkbox"/> DMHA or designee | 0 Health Care Staff | |

Documents Reviewed

- | | | |
|---|--|--|
| <input checked="" 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 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 type="checkbox"/> PAR Reports | 18 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 | 5 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 5 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

- 5 Youth 5 Direct Care Staff 0 Other

Observations During Review

- | | | |
|---|--|--|
| <input type="checkbox"/> Admissions | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input type="checkbox"/> Confinement | <input checked="" type="checkbox"/> Program Activities | <input checked="" type="checkbox"/> Tool Inventory and Storage |
| <input checked="" type="checkbox"/> Facility and Grounds | <input checked="" 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"/> Transition/Exit Conferences |
| <input type="checkbox"/> Group | <input checked="" type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings |
| <input checked="" type="checkbox"/> Meals | <input type="checkbox"/> Sick Call | <input type="checkbox"/> Use of Mechanical Restraints |
| <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 Quality Improvement review the agency has focused heavily on increasing longevity in the program with youth and staff. The agency has implemented a Length of Stay Initiative at its central shelter. The goal is to bring up the average length of stay for its residential youth to 35 days. A color-coded sticker system has been put into place on the general alert board, so staff can quickly tell how long a youth has been in the shelter. This allows staff to focus more efforts on youth who have been in the shelter shorter periods of time, to increase their chances of staying longer. A reward system has also been put into place for the youth and as they reach the next level, relating to their length of stay, they are given various rewards for their efforts.

The shelter has implemented "Jesus Loves" boxes, which is partnership with a faith based group to provide materials for a faith based objective.

The agency had a volunteer who developed a booklet and does "kiddie focused" groups with the kids.

The agency recently received their three year CARF re-certification.

The agency is trying to get financial support to build a new shelter. They are currently working with the Florida Network and D.C. to receive funding and are second on the list.

The non-residential pilot program, SNAP, Stop Now And Plan, has only resulted in one intake and is very time consuming. Financially it has cost the agency a lot of money. It ends May 26, 2015 and has not been beneficial.

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 (3) CINS/FINS program locations report to the agency's Chief Executive Officer and Chief Operations Officer that are located in 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 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 (3) service locations in their respective service areas. Other uniform program and operations protocols for all 3 locations include training and professional development exercises.

The CDS Behavioral Healthcare agency conducts background screenings prior to 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 to ensure that all staff members received 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

Eighteen newly hired staff were reviewed for initial background screening. A background screening was completed prior to hire for each new hire reviewed. Seven staff were applicable for a five-year background rescreening. A background rescreening was completed for each applicable staff, though two were not submitted ten days prior to the anniversary of hire date and were late by five and eight days, respectively. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Department's Background Screening Unit on January 23, 2015. Ten volunteers were reviewed. Documentation showed staff received training prior to the completion of a background screening for seven of the volunteers, though volunteer logs showed that the screenings had cleared prior to the volunteers providing services.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The employee handbook addresses staff conduct and expectations. The handbook specifically addresses child abuse reporting, work rules, and the code of conduct. Each staff signs an acknowledgement form for receipt of the handbook. The form documents a witness for the employee's signature as well. There have not been any abuse calls made against staff during the past year. There were multiple instances of staff reporting abuse to the Florida Abuse Hotline based on instances of abandonment or allegations youth made against parents/guardians, caregivers, or other adults. The phone number for the Florida Abuse Hotline was posted in the living and common areas of the shelter. Youth are given instructions during the orientation process on their right to contact and how to contact the Florida Abuse Hotline.

All five youth surveyed reported they know about the abuse hotline and where the number is located; however, none of them has had any reason to call. All five reported that staff are respectful when speaking with the youth. Four of the five youth reported they have not heard staff use inappropriate language and one youth reported hearing a youth care worker use it. All five youth feel safe in the shelter.

All five staff surveyed reported they have never heard another staff member deny a youth access to the abuse hotline. All five staff also reported they have never heard a co-worker use profanity, threats, or intimidation when interacting with the youth.

1.03 Incident Reporting

Satisfactory
 Limited
 Failed

Rating Narrative

The program had twenty-two incidents reported to the Department's Central Communications Center (CCC) in the past twelve months. Twenty-one of the incidents were reported within two hours of the incident or knowledge of the incident. In the remaining case, the incident occurred at 12:15 p.m. and an investigation into the incident followed. The program's internal report documented staff were informed to call the CCC at 3:00 p.m. and the call was taken by the CCC at 3:49 p.m. This incident was not classified as a failure to report by the CCC.

1.04 Training Requirements

Satisfactory
 Limited
 Failed

Rating Narrative

The provider has developed a new tracking system for training, utilizing Excel sheets for each employee. The system tracks training by fiscal year and quarter, thus annual training hours for all staff are tracked and tallied from July 1 to June 30 rather than by hire date. The Excel sheets are not placed in files, though are available electronically. Training files are maintained for each employee, though employees maintain documentation of their own training and then turn it in once completed. It was found that the training maintained by employees was not consistently transferred to training files maintained by the program and the hours were not reflected on the Excel sheets.

Training files for four new hires were reviewed, which include three residential and one non-residential staff. All four staff completed program orientation, suicide prevention, fire safety, and cultural competency. Documentation provided showed the non-residential staff completed 109.5 hours of training. Documentation for residential staff showed none had completed or were on pace to receive 80 hours of training in their first year of employment. All staff had current First Aid and CPR certifications, which were accomplished within one month of hire for one staff, within six months for two staff, and at eight months for one staff. All four new hires received training in CINS/FINS Core, though the training was only one hour for the residential employees and three hours for the non-residential employee (the training plan showed six hours). None of the new hires received training in crisis intervention and none of the residential staff received training in Title IV-E procedures. One residential staff did not have documentation of training in infection control.

Training files for four staff in subsequent years of employment were reviewed, which included three residential staff and one non-residential staff. The non-residential staff completed 95 hours of training, though her CPR and First Aid certification expired in March 2015. Two of the three residential staff had current First Aid and CPR certifications. The remaining residential staff had certificate of completion for Part I of the Heartsaver First Aid, CPR, AED online course, but the certificate clearly indicated completion of the online portion of course did not constitute successful completion or certification. The three residential staff did not have documentation of annual training in fire safety, crisis intervention, or infection control. Documentation reflected none of the residential staff had completed 40 hours of training. The training hour totals for the residential staff were 26, 22.5, and 15.5.

1.05 Analyzing and Reporting Information

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has very detailed reports that go out on a monthly basis in the CDS Performance and Risk Management Reports. These reports include performance analysis reporting on bed days and CINS nonresidential. It is broken down to review all of the admission, discharge and care day information per facility for the agency. This monthly report also includes a data lag report and analysis and projections of contractual

requirements from NETMIS. The monthly report also includes an incident report summary for all programs. In addition to those reports there is an analysis of the residential and nonresidential admissions, daily populations, average length of stay and bed days for the last 5 fiscal years. The agency is also reviewing customer satisfaction data bi annually with their management team. In June of each year the agency produces an annual data packet that includes cumulative Performance and Data Management results for the entire contract year for all programs.

The agency conducts Peer File reviews to determine the accuracy and completion of its clients files on a quarterly basis. A review of each file is completed according to the requirements of the DJJ QI Indicators that include section 2.01-2.07. The review process involves assessing client file practice to identifying deficiencies, trends, patterns and completeness of files and to correct these findings accordingly.

The CDS agency is also a pilot site for the DJJ SNAP program.

The agency still maintains its DCF Substance Abuse Licensure for its Central –Gainesville office. This license affords the agency the ability to help address youth with substance abuse prevention efforts. Serious or chronic substance abuse issues are referred to Meridian Behavioral Health Services Inc. the local SAMH provider.

CDS Family and Behavioral Health Services, Inc. is an accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). The agency wide CARF accreditation is valid through April 2018.

The agency has implemented a Length of Stay Initiative at its central shelter. The goal is to bring up the average length of stay for its residential youth to 35 days. A color-coded sticker system has been put into place on the general alert board, so staff can quickly tell how long a youth has been in the shelter. This allows staff to focus more efforts on youth who have been in the shelter shorter periods of time, to increase their chances of staying longer. A reward system has also been put into place for the youth and as they reach the next level, relating to their length of stay, they are given various rewards for their efforts.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The non-residential Counseling Program provides services for youth and their families in primarily Alachua, Gilchrist and Levy Counties. The program receives calls for service from parents, guardians, system partners, and the general community. The non-residential component for CDS Central consists of five (5) Non-Residential Counselors, one of which is a Licensed Mental Health Counselor (LMHC), one holds a Ph.D., and two are registered mental health interns. 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 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 schools 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 three non-residential and three residential files reviewed. All three non-residential files appeared to be reviewed within seven days of referral and intakes were completed promptly. The youth and parents/guardians were all informed of their rights and responsibilities, grievance procedures, and available service options. This was evidenced in the non-residential files by parent signature and documentation in the progress notes.

All three residential files reviewed included screenings completed within seven days of referral and the required residential orientation package components for the parents/guardians and youth were included in the files.

Two minor exceptions noted are one residential file did not include the parent checking each box on the orientation checklist and one residential file did not include the youth checking each box on the orientation checklist.

2.02 Needs Assessment

Satisfactory
 Limited
 Failed

Rating Narrative

There were three non-residential and three residential files reviewed. In all three non-residential files reviewed the psychosocial assessments met the goals being assessed in the CINS/FINS assessment. The policies and procedures of the agency, service availability, and grievance are in a centralized packet, making it user friendly and tidy for the consumer. All three files reviewed had psychosocial assessments completed by Bachelor/Masters level staff and signed by the supervisor.

The psychosocial assessments contained demographic information, dates of assessment, reason for the referral/presenting problems, input from the youth and family on what s/he wanted to change, psychiatric/counseling history, mental, physical, emotional status, education history, family history and involvement, youth residential history, development history, medical history, legal history (DJJ/DCF), financial/employment history, drug and alcohol history, peer relationships, potential for violence/abuse, history of violence/abuse, strengths and weaknesses, and interests. All of the assessments were organized and legible to review. Staff completed a summary with their impressions and comments. The recommendations were designed to assist the youth and family with the problems identified by the family, as well as, the referral source.

The risk factors assessment questions were administered to all youth at the first meeting. One of the cases identified a youth with an elevated risk of suicide. A referral to a licensed mental health professional was made. Further follow up with the youth and parent were made by staff as evidenced in case file progress note/or copy of referral found in file. Safety contract was also develop with the youth.

All three residential files reviewed met the standard as the psychosocial assessments were completed by staff with a bachelors degree or higher, signed by the counselor and supervisor, and completed within the required time frames.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

There were four non-residential and three residential files reviewed. All four non-residential service plans were easy to read, comprehensive, and designed to meet the needs of the youth and family as identified in the assessment summary and recommendations. The service plans included therapeutic goals and the treatment modalities were on target. Counselors/Case Managers address the youth's service problems identified in the needs assessments.

All four service plans contained the identified needs and goals; service type, frequency, and location of services; persons responsible; target dates for completion and actual completion dates as appropriate; and date the plan was initiated. The signatures of the youth, parent/guardian, counselor, and supervisor were obtained. Two of four service plans were developed within the seven days of psychosocial assessment.

Two of the cases reviewed were not yet due for service plan reviews. The other two cases were closed non-residential files and four of six reviews were completed every thirty days for the first three months.

Exceptions: When the parent is not available or contacted via phone it needs to be properly documented on the service plan and progress notes.

All three residential files reviewed had service plans initiated within required time frames. All service plans had signatures by the counselor, youth, parent/guardian and supervisor, and goals, with completion dates when applicable, related to the issues identified at intake and in the psychosocial assessment.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

There were four non-residential and three residential files reviewed. All four non-residential files were able to establish supportive services rendered to the youth and family. Referrals were made as needed and tracked as evidenced in the progress notes, the records also showed regular communication with mental health providers, parents, DJJ attorneys, and school board.

All four files also showed evidence of effective case monitoring and regular communication with the parent and the youth. At discharge from services, discharge plans and after care plans were developed, including linking and referring to mental health providers for the continuity of services and providing the family with supportive information.

All three residential files reviewed adequately reflected the counselor working with the youth and their family to provide support, address issues, facilitate referrals when indicated, and formulate discharge plans.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

There were four non-residential youth files reviewed. All four files showed that the youth and families received counseling services in accordance with the needs identified in the needs assessment and service plan. The youth and family needs were clearly identified in the presenting problem statement, the psychosocial assessment, the service plan, and case management. Further, the monitoring and coordination of services was healthy as evidenced by follow up services, referrals, and linking youth and family. Chronological case notes on the youth's progress were maintained in all files. All files contained signatures of supervisory review by a LMHC.

All three residential files reviewed included a detailed case plan to address issues/concerns identified at intake and further evaluation done during the psychosocial assessment.

In the three residential files reviewed the youth received group counseling five days per week and individual sessions as indicated on the service plan.

One minor exception noted was the group sign sheet was not signed by any of the youth on March 19, 2015. Only the date, typed youth names and group topic was included.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

One nonresidential youth file was reviewed, participating in case staffing services. In this case proper notification was given to the school representative and DJJ attorney. The mother was not invited to the initial meeting. The following committee meeting proper efforts were made to invite the mother to the 4/3/2015 meeting. The family was provided a written report outlining the committee recommendations.

Case re-opened on 4/3/2015. The case was referred for Case Staffing Committee it appears in May of 2014 by the Juvenile Dependency Division, Aluchua County, Florida. However, the case staffing committee request was sent to DCF. CINS/FINS program learned about it in January 2015. Soon after CINS/FINS consulted with DJJ attorney. DJJ attorney suggested a meeting to discuss details of case. A meeting was immediately scheduled with the school board members and DJJ attorney and program staff on 2/13/2015 for consultation and discuss services for the youth and family.

The following case staffing was scheduled for 4/3/2015. Progress notes show that the parent was notified on a timely manner, and copy of the letter sent to the parent. Case staffing was held on this date, recommendations made. The mother was informed of the recommendations as copy of the recommendations was provided to the mother including the next case staffing date on 5/7/2015. The case was open for services with CINS/FINS on the same date of the case staffing with the mother, 4/03/2015.

A reminder Email was sent on 5/04/2015 to the school representative and another reminder email was sent to the mother on 5/4/2015.

Given the short notice given to the staff in organizing the initially staffing and initiating services with the family. The staff was diligent and speedy in ensuring the members and family had the necessary information to pursue with the meeting and connect family with appropriate services.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

There were four non-residential and three residential files reviewed. All files were marked "confidential" and files are kept in a secure room. All files were organized in a neat and orderly manner and contained a checklist, which allowed for quick and easy access to information.

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 (12) 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 10-12 residents. The female and male sides of the facility are equipped with a large dorm, bath rooms and a dayroom. The facility includes a kitchen and dining area, Youth Care Work station, staff offices and a smaller meeting rooms, 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 a private wood fencing.

The program staff for the Residential staff includes a Regional Coordinator, a Residential Supervisor, twenty-three (23) full-time and part-time Youth Care Workers and one (1) administrative staff person. Two (2) Residential Counselors are assigned to provide counseling and case management services to the residential program. The Direct Care Worker staff members 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

A tour of the facility and grounds found the program to be clean, safe, and well maintained. The grounds include several large trees and other landscaping. All furnishings were in good repair. There are separate dorms for male and female youth, with each dorm able to house up to twelve youth through the use of bunk beds. The bathrooms and showers in each dorm were clean and functional. Each youth had an individual bed with mattress, sheets, blankets, and pillow. Each youth had a crate for personal belongings and hygiene items for each youth were stored in the staff office in individual containers. The program was free of graffiti and it was evident that staff immediately removed or painted over any graffiti. Lighting was adequate throughout the facility.

All fire safety inspections were current, which included inspections of the fire alarm system, fire extinguishers, the sprinkler system, and the annual fire safety inspection. Any deficiencies were corrected. The hood in the kitchen was also inspected and cleaned. The program documented monthly checks of fire extinguishers.

Food service inspections were completed by the Alachua County Health Department quarterly. A Residential Group Care Facility inspection was completed by the Alachua County Health Department in October 2014. All inspections completed by the health department were rated satisfactory.

The program was free of bugs and other insects. An annual termite inspection and monthly pest control by a local professional were documented.

The program has an internal Safety and Maintenance Inspection form. The form indicates inspections should occur weekly. Documentation reviewed found the internal inspections were not consistently completed on a weekly basis, especially during the past three months.

The program schedule is posted in each dorm. The schedule provides for a variety of activities, to include at least one hour of outside recreation each day, time for homework each evening, counseling, life and social skills training, and other activities. Faith-based opportunities are provide to youth on a regular basis. Youth are not required to participate in the faith-based activities and other activities are available to youth who choose not to participate.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

Five residential files were reviewed. Program orientation was documented within twenty-four hours in each file reviewed. The orientation covered all required elements, to include but not limited to youth receiving information on how to contact the Florida Abuse Hotline, youth rights, the grievance procedure, emergency procedures, contraband, consequences for rule violations, a tour of the facility, visitation and telephone procedures, and how to access health, mental health, and substance abuse services.

3.03 Youth Room Assignment

Satisfactory
 Limited
 Failed

Rating Narrative

Youth classification and room assignment was documented in each of the five residential files reviewed. Classification reflected documentation for all required elements with the exception of collateral contracts and gender identification. The classification form in each case documented the youth's age, gender, size, and physical characteristics and identified any applicable disabilities, gang affiliation, or violent or sexually aggressive history.

The form used for classification does not address gender identification or reflect collateral contacts.

3.04 Log Books

Satisfactory
 Limited
 Failed

Rating Narrative

Logbooks were reviewed; safety and security issues appeared to be documented appropriately. All entries are brief and made in ink. Some entries were harder to read. Residential Supervisor reviewed logbook and noted that all recording errors are to be struck through with a clear line with staff initial and date. There were some inconsistencies in regards to what information is highlighted. Visitation and home visits were documented. It was observed that the supervisor and staff were reviewing the logbook in a timely manner.

3.05 Behavior Management Strategies

Satisfactory
 Limited
 Failed

Rating Narrative

The Behavior Management System appears to be very detailed and explained during program orientation as observed by staffing training booklet, intake documentation signed by youth, signs posted in the shelter. Interviewed staff reported being training in the FACE system and are able to clearly explain the BMS to others. The program uses the "FACE" system that is designed to gain compliance with program rules, influence positive behavior and increase accountability. The system appears to promote order, safety, security, respect, fairness, and protection of youth rights. There is adequate written feedback showing the progress or regress of the youth's behaviors. The BMS provides for positive reinforcement and recognition; constructive dialogue and peaceful resolution. The consequences appear to be in compliance with Florida Network and DJJ standards.

3.06 Staffing and Youth Supervision

Satisfactory
 Limited
 Failed

Rating Narrative

This Program has a policy for staffing and youth supervision that complies with DJJ policy. The master staff schedule is kept in a binder with staff contact numbers.

Bed checks are completed and documented using an electronic scanner. Printouts from the bed check program were reviewed. The majority of the checks were done within the designated fifteen (15) minute time frame. Staff were observed via camera footage following their bed check procedures. The Shelter has a ten-camera surveillance system that is monitored by staff. The system provides backup for up to 60 days. Program utilizes part-time and prn male staff to meet male and female staffing guidelines as needed.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The Program has a well-documented policy regarding special populations: Staff Secure, Domestic Violence Respite and Probation Respite youth that complies with the DJJ standards. The program reports that they did not provide any staff secure or probation respite services in the past six months or since the last onsite QI review was conducted. Three domestic violence respite files were reviewed, two open and one closed. All youth admitted to DV Respite placement have pending DV charges as evidenced by documentation in file from the JAC/Detention center, but do not meet criteria for secure detention. Youth length of stay in DV Respite placement did not exceed 14 days. When appropriate youth were transition to CINS. Case plans in files reflects goals focusing on aggression management, family coping skills, or other interventions designed to reduce reoccurrence of violence in the home. All other services provided to DVR youth are consistent with all other general CINS/FINS program requirements.

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 East 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 resident 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. Youth are admitted to the shelter with prescribed or over the counter medication. The agency secures these medications at that time. Medications are stored in a secure location that is inaccessible to residents. The facility is equipped with multiple first aid kits, knife for life and wire cutters. The staff members are trained to provide CPR and First Aid services in case of an emergency. As of the date of this onsite review, all fire safety equipment is up to date and functioning.

4.01 Healthcare Admission Screening

Satisfactory
 Limited
 Failed

Rating Narrative

The agency utilizes policies P-1117 and P-1118 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. If there are any health concerns that require a follow-up they are addressed at that time through consultation with the parent/guardian and documented on a Medical Health Follow-Up Form.

A total of five open 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. One of the five files documented the youth was on medication.

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 eleven health issues.

4.02 Suicide Prevention

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a Mental Health, Substance Abuse, and Suicide Risk Screening policy in place last reviewed on January 17, 2014. 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) and reviews suicide risk assessments completed at the shelter. The shelter employ's two Master's level counselor who complete all suicide risk assessments and then consult with the LMHC. The non-residential program employs four master's level counselor, one of which is a LMHC and three who are Registered Mental Health Counselor Interns. There is an additional counselor who holds a Ph.D.

There were six youth files reviewed for youth who had been placed on suicide precautions, four open and two closed. All six 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 accessed by a master's level counselor, using a suicide risk assessment, within twenty-four hours. All suicide risk assessments contained documentation of consultation with the 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 six youth had thirty minute observations documented the entire time they were on suicide precautions. All suicide precaution events were documented in the logbook.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a Medication policy that addresses all major areas of medication distribution and assisting in the delivery of Medication. The policy is called the Medication Provision, Storage, Access, Inventory, and Disposal. The agency medication policy was last updated in October 2014. The current policy P-1120 includes twelve sections that address the following: Prescription Medication; Procedure for Verification of Medication; Non-Prescription Medication; Medication Provision, Supervision, and Monitoring; Medication Distribution Away from the Shelter; Medication Errors and Refusals; New Prescription, Change in Medication and New Month; Medication Storage; Access to Medication; Inventory Procedures; Medication Counting Procedures; Discharge of Youth with Medication; and Disposal. The agency does not provide youth with over the counter (OTC) medications. All youth that require an OTC medication must have a doctor's prescription accompanying the youth at admission to the program.

Trained staff members assist youth in the self-administration of prescribed medications. When the medication is given youth and staff initial the designated space on the Medication Record Log and staff then records the remaining count in the designated space. All medications are stored in a locked medication cart in the staff work area between the male and female dorms. This area is inaccessible to youth unless accompanied by a staff member. The cart is double-locked and each youth has their own separate Tupperware container for their medication. All topical medications are stored in a separate drawer and a small, locked, refrigerator is located in the same area for any medications requiring refrigeration. Controlled medications are locked in a separate container inside the medication cart. The shelter does not give over-the-counter (OTC) medications, unless prescribed, so therefore there are no OTC's to inventory. There was a small supply of sharps, disposable razors youth can bring in, located in a drawer in the staff office; however, there was no weekly inventory maintained for these razors.

There were five youth files reviewed to verify the medication administration process. The parent/guardian completes the Parent/Guardian Consent Regarding Medication form at intake which lists all the medication the youth is taking, reason for the medication, and the count. The parent/guardian, youth, and staff member all sign the form. This form was completed in all five files reviewed. The youth's Medication Record Log (MRL) is maintained in the youth's individual file. All MRLs reviewed documented the youth's name, a picture of the youth, allergies, side effects, 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. All MRLs documented medications were given in the time frame specified. A perpetual inventory with running balances was maintained on each MRL, as well as, shift-to-shift inventories for controlled medications and weekly inventories for non-controlled medications. There was also documentation on each MRL that the medication was verified by a pharmacist, there was documentation of the staff who verified the medication and who the staff spoke to at the pharmacy.

The shelter has had five CCC reports in the last six months relating to medication errors. Three of the reports were related to a youth receiving the wrong dose of medication and the remaining two reports were discrepancies in counts. One of the incidents relating to the youth receiving a wrong dose of medication was due to an error at intake and staff documented the wrong dosage on the MRL. The error was caught and

resolved on the day of admission. The youth's parent and doctor were contacted and reported there would be no adverse side effects. The staff member involved received a Corrective Action Memorandum. The other two reports of a youth receiving an incorrect dose of medication was the same youth in both reports and on two consecutive days staff administered an extra dose of medication. The youth's parent was notified, as well as, the pharmacist who reported to continue with the next scheduled dose and there would be no adverse side effects. There was also documentation of a Corrective Action Memorandum given to the staff member involved. The last two CCC reports were related to discrepancies in counts. These errors were discovered during medication counts and appears staff did not document when the youth received a dose of medication resulting in inaccurate counts. The four staff members involved in these incidents were required attend a re-training on the medication process and also received a Corrective Action Memorandum. The agency has also implemented a new system of color-coded stickers on the youth's MRL and on the alert board. The stickers give staff a quick reference when looking at the alert board as to what time of day the youth are to receive medication, yellow is for morning, blue is for lunchtime, red is for evening, and green is for bedtime. Staff interviewed reported this new system has been very helpful in the medication process because when they come for their shift all they have to do is look at the alert board and can very quickly tell which youth are to receive medication during their shift. The shelter has not had any medication errors since February 2015. Staff interviewed were very knowledgeable of the medication process.

4.04 Medical/Mental Health Alert Process

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has an effective medical and mental health alert system policy. The current policy is call P-1119 Medical and Mental Alert Process. The agency has a comprehensive Participant Code that includes eighteen codes for various alerts that can occur in the shelter setting. The agency places the appropriate number next to the youth's name on their large General Alert Board, located in the Youth Care Worker (YCW) office, for all staff to quickly locate as needed. The code definition sheet is placed taped to the wall located in the YCW work office. The agency also places participant codes on the youth information strip located on the spine of the youth's file. All applicable dietary alerts and food allergies are also posted in the kitchen.

A total of five open files were reviewed for adherence to this indicator. All files reviewed had an alert that was appropriate to their screening and assessment results. All alerts documented on the youth's file corresponded with the alerts documented on the General Alert Board. All dietary alerts were posted in the kitchen.

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. The Shelter has not had any emergency or episodic care events since the last Quality Improvement Review.

All staff are trained in CPR, first aid, and AED, with the exception of one staff member whose had expired in March 2015. The shelter has an Emergency/Episodic Care Log in place in case an event happens. Also the shelter completes emergency medical and dental drills in order to prepare staff for an actual event. The shelter has first aid kits located throughout the building and a knife-for-life and wire cutters.