



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

Review of CHS Treasure Coast, WaveCREST

on 05/24/2017

## CINS/FINS Rating Profile

### Standard 1: Management Accountability

1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

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

### Standard 3: Shelter Care

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

Percent of indicators rated Satisfactory:87.50%  
Percent of indicators rated Limited:12.50%  
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%

Percent of indicators rated Satisfactory:96.30%  
Percent of indicators rated Limited:3.70%  
Percent of indicators rated Failed:0.00%

## Rating Definitions

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

Satisfactory Compliance	Non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.
Not Applicable	Does not apply.

## Review Team

### Members

**Ashley Davies, Forefront LLC, Lead Reviewer and Consultant**

**Ivonne Fusco, Lutheran Services Florida SE (Lippman), Senior Administrative Assistant**

**Terrance Reed, Urban League, CINS/FINS Supervisor**

**Paula Friedrich, Department of Juvenile Justice, Regional Monitor**

**Tonya Gittens, Department of Juvenile Justice, Regional Monitor**

**Persons Interviewed**

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

**Documents Reviewed**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports                        | <input checked="" type="checkbox"/> Fire Prevention Plan             | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records        | <input type="checkbox"/> Visitation Logs                       |
| <input checked="" type="checkbox"/> CCC Reports                       | <input type="checkbox"/> Key Control Log                             | <input checked="" type="checkbox"/> Youth Handbook             |
| <input checked="" type="checkbox"/> Logbooks                          | <input checked="" type="checkbox"/> Fire Drill Log                   | 5 # Health Records   |
| <input checked="" type="checkbox"/> Continuity of Operation Plan      | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 # MH/SA Records  |
| <input type="checkbox"/> Contract Monitoring Reports                  | <input checked="" type="checkbox"/> Table of Organization            | 11 # Personnel Records   |
| <input type="checkbox"/> Contract Scope of Services                   | <input checked="" type="checkbox"/> Precautionary Observation Logs   | 6 # Training Records   |
| <input checked="" type="checkbox"/> Egress Plans                      | <input checked="" type="checkbox"/> Program Schedules                | 5 # Youth Records (Closed)                                     |
| <input checked="" type="checkbox"/> Fire Inspection Report            | <input type="checkbox"/> Telephone Logs                              | 5 # Youth Records (Open)                                       |
| <input type="checkbox"/> Exposure Control Plan                        | <input type="checkbox"/> Supplemental Contracts                      | 0 # Other  |

**Surveys**

4 Youth                      4 Direct Care Staff

**Observations During Review**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Intake                                    | <input checked="" type="checkbox"/> Posting of Abuse Hotline         | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input checked="" type="checkbox"/> Program Activities             | <input type="checkbox"/> Tool Inventory and Storage                  | <input checked="" type="checkbox"/> Facility and Grounds       |
| <input type="checkbox"/> Recreation                                | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage | <input checked="" type="checkbox"/> First Aid Kit(s)           |
| <input type="checkbox"/> Searches                                  | <input type="checkbox"/> Discharge                                   | <input type="checkbox"/> Group                                 |
| <input checked="" type="checkbox"/> Security Video Tapes           | <input type="checkbox"/> Treatment Team Meetings                     | <input type="checkbox"/> Meals                                 |
| <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input type="checkbox"/> Youth Movement and Counts                   |  |
| <input 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

#### **Facility Improvements**

The agency has installed a new surveillance DVR System with increased memory capacity.

The shelter was the recipient of a Sherwin Williams Paint Day and had the exterior of the shelter and pavilion painted.

The air conditioning unit in the shelter was replaced.

New carpet was installed throughout the shelter bedrooms, offices, and porch area.

The agency purchased a new front loading washer and dryer for the shelter.

The shower stalls and bathroom renovations were completed. The aged tile grout in the floors and shower areas were replaced with fiberglass shower enclosures and new flooring. New sinks, toilets, cabinetry for youth hygiene products, mirrors, the addition of a handicap accessible bathroom and replacement windows were also part of the renovation. Dining room/living room area floors were also replaced as well as hallways. Funding was made possible through a partnership with local Continuum of Care.

Arrangements with the St. Lucie County Sheriff's Department were established for the provision of free lawn maintenance, saving the program dollars that are then able to be allocated elsewhere.

#### **Programming Improvements**

The shelter established arrangement with two service providers to address the gaps in attaining services for residents and their families. When appropriate, Drug Abuse Treatment Associates (DATA) and Sun Coast Mental Health are able to provide services while youth are still in shelter, removing barriers (perceived or real) to ongoing services.

A Data Management Specialist position has been added.

Laptop computers were purchased for the Outreach Non-Residential Counselors.

#### **Challenges**

The agency has had some challenges hiring Youth Care Staff.

There have been some vacancies in Non-Residential CINS/FINS positions, one was recently filled and one is still vacant.

There were some inconsistencies identified in the process of referring youth. Quality Management conducted retraining with staff to clarify and improve the process.

## Standard 1: Management Accountability

### Overview

#### Narrative

WaveCREST provides shelter and non-residential services for youth and their families in Martin, St. Lucie, Okeechobee, and Indian River Counties. The program is located at 4520 Selvitz Road in Ft. Pierce, Florida and is under the leadership of a Program Director. In addition other staff include: a Residential Supervisor, a licensed Clinical staff, an Administrative Secretary, Residential Counselor and an Outreach Counselor. Shelter staff includes: a Data Specialist, Group Living Manager, five fulltime Youth Care Staff (YCS), and three part time/relief Youth Care Staff. There were two full-time YCS positions vacant and two relief YCS positions vacant.

The program provides orientation training to all personnel through the agency's Learning Management System (LMS). Each employee has a separate training file containing a training plan and corroborating documentation for training received. Annual training is tracked from the Employees' date of hire initially then transitioned over to the calendar year thereafter. The program provides training through a combination of web-based and instructor-led courses.

In order to ensure management accountability, the program has a Continuous Quality Improvement program and a designated Quality Management Specialist (QMS) who is responsible for the implementation and oversight of its CQI program. In practice, the program's CQI program includes many activities that are conducted by various staff to ensure all aspects of analyzing and reporting data are consistently implemented and documented.

### 1.01 Background Screening

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy and procedures in place, last updated August 23, 2016. Policy number CHS 7101 addresses the requirements of the indicator for background screening of employees and volunteers.

The policy reviewed onsite requires all potential employees, volunteers who work alone with youth, and interns to successfully complete a background check prior to an offer of employment or provision of service within the program. The program's policy requires these individuals to undergo a Level 2 Employment Screening pursuant to Rule 65C-14.023 and Florida Statutes. Additionally, the provider conducts a background check with the Division of Motor Vehicles prior to hiring staff and a review is conducted annually. Every January staff will complete an Affidavit of Good Moral Character. The report is submitted to the DJJ Background Screening Unit by January 31st.

The program maintains personnel records of employee background screenings in the agency's HR database. The reviewer interviewed the program's HR Associate and viewed electronic copies of each completed background screening requested.

A total of eleven background screening files were reviewed for ten new hires and one intern. There were no employees who were eligible for a 5-year background screening during the review period. The ten new personnel had timely background screenings completed prior to their hire dates. Similarly, the one intern received an eligible screening result prior to their volunteer service start dates.

The program provided a copy of its Annual Affidavit of Compliance with Level 2 Screening Standards and evidence that it was submitted to the BSU on November 22, 2016.

There were no exceptions to this indicator.

### 1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a policy CHS/7102 in place for the provision of an abuse free environment updated on 8/23/16. The policy requires the shelter to post the abuse hotline phone number, staff training on child abuse reporting, and client grievance procedure in areas accessible to the youth.

The provider accomplishes this through staff training, reporting suspected or alleged abuse, communicating to staff the behavioral expectations, and the agency's code of conduct.

During the tour of the facility it was observed that the Florida Abuse Hotline number and other relevant numbers are posted in the male and female rooms. Youth are also informed of these during program orientation.

Upon hire, staff receive and sign receipt of the Agency's Code of Conduct which is included in the Employee Handbook. Employees are required to report all known or suspected cases of abuse and are trained on child abuse reporting. During review, reviewed were three staff files. All three completed training on child abuse reporting.

The program also has a grievance box and forms available to youth so that youth grievances can be accepted and resolved by staff. During the review, reviewed were four grievances. Four were resolved promptly and provided resolution in writing on the grievance forms.

There were no exceptions for this indicator.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy CHS/7103 outlining the Incident Reporting procedure. It was updated on 8/23/16 and complies with procedures and guidelines by the Quality Improvement indicator and the Florida's Network Policies and Procedures. In addition, the agency has a Risk Management policy to identify trend or minimize potential risks.

The agency has implemented policies and procedures regarding incident reports and risk management that will prevent risk of accidents and injuries to clients. Qualifying incidents will be reported to the CCC as soon as possible.

Program maintains information about incident reports in a paperless computer database system called Airsweb.net. A list of incidents was provided for the last six months. There were fifteen incidents reported to the CCC between 11/1/16 and 5/22/17. There was one incident reported outside of the two hour time frame. The incidents included: medical transports, contraband, runaways, and medication errors. The program completes follow-up communication tasks/special instructions as required by the CCC. All incidents with the exception of one were documented in the program log book.

All incident reports are electronically generated, documented, reviewed, and signed online.

#### Exceptions:

One incident was reported outside of the two hour frame.

One incident was not documented in the program log book.

### 1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy for Training Requirements that was last updated on April 15, 2017. The policy number is CHS 7104.

Training is provided through various means including online using the agency's Learning Management System (LMS), the Florida Network, DJJ Skill Pro platform, and external professional trainers. The program director develops an Individual Training Plan with each staff annually and monitors training on a monthly basis to ensure staff receives the required training throughout the year. Monthly training calendars are maintained in a binder along with sign-in sheets and curriculums for trainings conducted each month.

The program maintains an individual training file for each staff member that contains four sections: 1) a log of training courses/hours completed, 2) training plan, 3) training needs assessments, and 4) supporting documentation and certificates. The program has an established procedure requiring certain trainings to be completed by new hires within the first 90 to 120 days of employment and a total of 80 hours of training within the first year of employment which must include the courses named as both required and recommended by the indicator.

In addition to its policy and procedures, the provider has an annual Training Plan for FY 2016-2017 that describes its protocol for complying with the training requirements.

There were three training files reviewed for new hire training completed during the first 120 days of employment. All three staff received all trainings required within the first 120 days, with the exception of Managing Aggressive Behavior (MAB). These three staff did receive MAB training; however, it was after the first 120 days. All three staff still had time remaining in their first year training cycle but had already received all required first year trainings and documented well over the required 80 hours of training for the first year of employment.

There were three training files reviewed for annual in-service training requirements. All three staff documented more than the required 40 hours of annual training. All three staff documented all required trainings, as well as, additional trainings.

**Exception:**

Three new hires did not have MAB in the first 120 days but did get it in the first year of employment.

### 1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy CHS/7105 for Reporting and Analyzing Data updated on 8/25/16. Their system data collection and recording for contract compliance serves to identify patterns and trends.

The program collects and reviews several sources of information to identify patterns and trends including: monthly outcomes; quarterly case record review reports; monthly review of incidents, accidents and grievances; monthly review of program satisfaction surveys; monthly review of NetMis data reports. The program has a Quality Management department that oversees the program outputs and outcomes for the quality improvement process. Findings of data collected and reviewed are shared with staff, identifying strengths and weaknesses as well as improvements to be implemented or modified with staff input.

The program has a designated Quality Management Specialist who is responsible for the implementation and oversight of the CQI program. All these activities are kept online on the database system called

### Airsweb.net.

A binder with Staff Monthly Minutes were provided for review. There was documentation in these minutes that all staff reviews training, incident & accidents, NetMIS data, record review, and satisfaction surveys.

Peer Case Reviews are conducted quarterly by program staff, upon completion of each record review the QMS aggregates the results and enters data into database system. The same process is done with incidents, accidents, and grievances.

Consumer Satisfaction and Outcome Data are administered on an ongoing basis and collected by QMS and entered into the database then submitted to the program supervisor for review.

On the staff meeting minutes there is evidence that staff reviews all data looking for strength and weaknesses, and improvements are implemented or modified throughout the process.

There were no exceptions to this indicator.

### 1.06 Client Transportation

Satisfactory

Limited

Failed

#### Rating Narrative

Agency has a transportation policy CHS/7106 that was effective on 9/1/15.

Youth will be transported with third party presence when at all possible. This third party may be another direct care staff, volunteer, intern, clinical, administrative staff, or another youth. All agency drivers are approved by administrative personnel to drive clients in agency vehicles. The HR department performs annual motor vehicle driving checks with the Florida Division of Motor Vehicles. All CHS employees who have been approved for driving have a valid Florida driver's license and are covered under the company insurance policy.

Each driver of a vehicle will log out the keys to the vehicle. The driver's log is maintained in a binder in the vehicle and consists of driver/staff's name, date and time, mileage, purpose of travel and location, number of passengers, and supervisor's approval space. There were several cases reviewed of single client transports. All were approved by the supervisor and documented a review of the client's history and recent behavior.

The program has cameras installed in both agency vans, including audio and video, to capture in the absence of the third party and are reviewed as needed.

The Agency performs annual motor vehicle driving checks. The last check from November 2016 was reviewed and shows all staff with an eligible status.

There were no exceptions to this indicator.

### 1.07 Outreach Services

Satisfactory

Limited

Failed

#### Rating Narrative

The Agency has an Outreach and Interagency Agreement policy CHS/7107 that was updated on 9/2/16. The policy outlines that Outreach is conducted by the program on an ongoing basis and that Interagency Agreements are utilized by CHS to build strong community partnerships and collaborations ensuring that

youth and their families served can receive appropriate services.

The program will participate in each of the local county councils and the DJJ Circuit 19 Advisory Board to ensure prevention programming and CINS/FINS services are represented. Identified CINS/FINS presenters will be provided to any organization that wishes to know more about the activities of CHS. Outreach strategy includes the implementation of school and community presentations and a direct media campaign to target and educate youth.

CHS has a binder with Interagency Agreements. There are about thirty-four agreements with other intervention programs, medical, educational/recreation, clinical services, and food banks. Agreements were reviewed in August 2016.

Outreach Events that staff participate in on are recorded on NetMIS. The program maintains a binder with information from weekly conference calls for detention hearing meetings.

CHS participates on each local county council and the DJJ Circuit 19 Advisory Board to ensure prevention programming of CINS/FINS services are represented. All agendas and minutes are kept in a Community Meeting Participation binder.

There were no exceptions to this indicator.

## Standard 2: Intervention and Case Management

### Overview

#### Rating Narrative

WaveCREST is contracted with the Florida Network of Youth and Families to provide both shelter and non-residential CINS/FINS services for youth and their families in Martin, Okeechobee, Indian River, and St. Lucie Counties. The program provides centralized intake and screening twenty-four hours per day, seven days per week, every day of the year. Trained staff are available to determine the needs of the family and youth. Residential services, including individual, family, and group services are provided. Case management and substance abuse prevention education is also offered. Referral and aftercare services begin when the youth are admitted for services. Aftercare planning includes referring youth to community resources, on-going counseling, and educational assistance. Direct Care staff are responsible for completing all applicable admission paperwork, orientating youth to the shelter/program, and providing necessary supervision.

The program has a very strong, efficient, well run centralized intake process in place. All staff are well trained on the process display a knowledge of motivational interviewing, crisis counseling, and gathering all pertinent information in a very professional way.

The counseling component consists of a total of four counseling positions and a supervisor. One of those four counseling was vacant and another one was just recently filled approximately one month before the review. The counselors are responsible for completing assessments, developing case plans, providing case management services, and linking youth and families to community services.

CHS WaveCREST coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court.

### 2.01 Screening and Intake

Satisfactory                       Limited                       Failed

#### Rating Narrative

The agency has a written policy outlining the Screening and Intake procedure. It was updated on 7/1/2016 and it complies with procedures and guidelines by the Quality Improvement Indicator and the Florida's Network Policies and Procedures.

The provider accomplishes this by providing the youth and parents/guardians in writing during the intake with: Available Service Options and The Rights and Responsibilities of Youth and Parents. In addition, the following information is available to youth and parent/guardians: Possible actions occurring through the involvement with CINS/FINS services (i.e.) case staffing committee, CINS Petition, CINS Adjudication; and Grievance Procedure.

A total of five residential and five non-residential files were reviewed. All files reviewed indicated eligibility screening was completed within seven calendar days of referral. All files reviewed indicated youth and parents/guardians were provided with available service options, rights and responsibilities, possible actions occurring through involvement with CINS/FINS services, and grievance procedures in writing.

There were no exceptions for this Indicator.

### 2.02 Needs Assessment

Satisfactory                       Limited                       Failed

#### Rating Narrative

The program has a policy in place for the provision of Needs Assessment updated on 8/23/2016. The policy requires that a needs assessment is completed to gather and analyze information for all youth receiving services. The assessment contains the elements required by the Florida Network's Policy and Procedure Manual for CINS/FINS.

The procedure details the process staff follows for the completion of Needs Assessments. All Needs Assessments are to be initiated within the required time frames. All Needs Assessments include a suicide risk screening section.

There were five residential and five non-residential files reviewed. In all files the Needs Assessments were initiated within 72 hours and completed within two to three face-to-face contacts following the initial intake with youth that were receiving non-residential services or updated if most recent needs Assessment is over six months old. In addition Needs Assessment were completed by Bachelor's or Master's level staff and signed by a supervisor. In cases where the suicide risk component of the assessment was required (as a result of suicide risk screening), it was reviewed (signed and dated) by a licensed clinical supervisor or written by licensed clinical staff.

There were no exceptions to this indicator.

### 2.03 Case/Service Plan

Satisfactory
  Limited
  Failed

Rating Narrative

The program has a policy in place for the provision of Case/Service Plans updated on 8/23/2016.

The policy requires a Case/Service Plan to be developed with the youth and family within seven working days following completion of assessment. The plan is developed based on information gathered during initial screening, intake, and assessment.

There were five residential and five non-residential files reviewed. All Case/Service Plans were completed within seven working days following the completion of the assessment. Case/Service Plans were developed based on information gathered during the initial screening, intake, and assessment. All case/service plans reviewed included: identified needs and goals; type, frequency and location of services; persons responsible; target dates for completion, actual completion dates; signature of youth, parent/guardian, counselor and supervisor; and date the plan was initiated. In addition all Case/Service Plans were reviewed by counselors and parent/guardian every thirty days for the first three months for progress in achieving goals and necessary revisions were made to Case/Service Plans as needed.

There were no exceptions for this indicator.

### 2.04 Case Management and Service Delivery

Satisfactory
  Limited
  Failed

Rating Narrative

The Agency has a written policy for Case Management and Service Delivery updated on 08/23/2016. It mentions that each youth is assigned a Counselor/Case Manager who will follow the youth's case to ensure delivery of services through direct provision of referral.

The program has a process of case management which includes: 1) Establishing referral needs and coordinating referrals to services based upon the ongoing assessment of the youth's/family's problems of needs; 2) Coordinating service plan implementation; 3) Monitoring youth/family progress in services; 4) Providing Support for families; 5) Monitoring out-of-home placement if necessary; 6) Referrals to the case staff committee, as needed to address the problems and needs of the youth/family; 7) Recommending and pursuing judicial intervention in selected cases; 8) Accompanying youth and parent/guardian to court hearings and related appointments, if applicable; 9) Referral to additional services, if needed; 10)

**Continued case monitoring and review of court orders; 11) Case Termination.**

There were five residential and five non-residential files reviewed. All files reviewed indicated service plans were implemented and youth/family's progress was monitored. All files reviewed indicated need for referrals, and all provided appropriate referrals for additional services.

There were no exceptions for this indicator.

**2.05 Counseling Services**

Satisfactory                       Limited                       Failed

Rating Narrative

Agency has a policy in place for Counseling Services effective on 8/23/2016.

This shelter provides individual and family counseling, as well as, group counseling sessions held a minimum of five days per week, based on established group process procedures. Non-residential programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family in the event of crisis, keep families intact, minimize out-of-home placement, provide aftercare services for youth returning home from shelter services, and prevent the involvement of youth and families in delinquency systems.

Counseling services were provided as needed to all youth reviewed. Needs assessments and case plan reviews were held timely and addressed the youth and family needs. All five applicable files received counseling services in accordance with the Case/Service Plan. The program provides a variety of group sessions at least five times per week.

There were no exceptions for this indicator.

**2.06 Adjudication/Petition Process**

Satisfactory                       Limited                       Failed

Rating Narrative

The agency has a policy that addresses Case Staffing and Adjudication. CHS/7206 was last updated on 8/1/15.

CHS will hold a case staffing review for those cases documented as having insufficient progress or at the request of a parent/guardian. All of the requirements of the indicator are addressed in the policy and procedures.

There were two applicable files reviewed. In one case, the program received a written request from the parent requesting a case staffing because of youth's non-compliance. In the second case, the agency requested the case staffing because youth/family were non-compliant with services. Both case staffings were convened in seven working days and all parties were notified in a timely manner. As a result of the case staffings, a new or revised plan of services was created.

There were no exceptions for this indicator.

**2.07 Youth Records**

Satisfactory                       Limited                       Failed

Rating Narrative

**The agency has a Youth Records policy, effective since 8/23/2016, to ensure that the best practice is maintaining confidential records for each youth which contains pertinent information involving the youth and his/her treatment at the program.**

**The policy and procedure addresses how records are maintained and the levels of security required for files marked confidential.**

**All ten files reviewed were marked confidential and were kept in a locked file cabinet that was also marked confidential. In speaking with staff, all files that are transported are locked in an opaque container that is marked confidential. Also youth files are maintained in a neat and orderly manner so that staff can quickly and easily access information. All youth files were accessible only by program staff. Files were organized for optimal information retrieval.**

**There were no exceptions for this indicator.**

## Standard 3: Shelter Care

### Overview

#### Rating Narrative

WaveCREST Shelter is located in central St. Lucie County. The facility is licensed by the Department of Children and Families for 12 beds. The shelter also admits youth from the Department of Children and Families (DCF) and also for the Basic Center Program. In addition, the provider has a contract to provide residential services for youth referred by DJJ for domestic violence and/or Probation Respite. The shelter is designated by the Florida Network to provide staff secure services for up to ninety days or as court ordered.

The building occupied by the shelter program is over forty years old, and is leased by Children's Home Society from St. Lucie County. Each sleeping room is numbered and the beds are identified with letters. Four of the bedrooms house two youth, each with an individual bed, bed coverings and pillows. The other two bedrooms (male and female rooms) are equipped each with a bunk bed and a twin bed which gives the program the flexibility to accommodate more youth of one gender when necessary. All of the beds were recently furnished with new mattresses. Youth have access to a screened porch equipped with an AC unit, insulation, and state of the art exercise equipment.

### 3.01 Shelter Environment

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy set in place on Shelter Environment. Policy number CHS/7301 was last updated on September 12, 2016 and approved by the program director.

All Sleeping Quarters shall have adequate lighting. Staff will check rooms daily to assure that personalization of rooms are appropriate. Each youth will have their own bed to sleep on. Youth are encouraged to have personal belongings of value locked in the shelter safe by staff and inventoried. Kitchen, dining room area, bathroom and shower facilities shall be cleaned and maintained, checked daily and documented. Buildings will be inspected weekly for cleanliness and orderliness, to observe evidence of disrepair such as broken windows, peeling paint, broken furniture, and graffiti on the walls. Health and fire safety inspections are current. Furnishings are well maintained. Grounds are landscaped and well maintained. Shelter maintains a contract with an exterminator to insure the facility remains free of insect infestation. Interested youth will be given an opportunity to attend local religious services. Youth will be encouraged to read and may read in their rooms. At least one hour of physical activity is provided daily.

The environment of the shelter looks to be safe and clean. The shelter has a living and dining area, with the male and female dormitory on either side. Document reviewed proved that health and safety inspections are up-to-date and current. The last inspection was on May 9, 2017. All furnishings look to be in good condition. The shelter's last pest inspection was April 3, 2017. The facility grounds showed to be maintained. A walk through of the shelter showed that there were no graffiti on walls, or windows, along with bathrooms and shower area being clean and functional. There was adequate lighting throughout the hallway and rooms.

Youth are allowed to place personal belongings of value in a locked safe and inventoried at the shelter by staff, the safe is located in the pantry area. Document shows that the shelter has a structured daily schedule set in place for school days and weekend/holidays. All youth are encouraged to attend school throughout the week. The ones that remain in the shelter are to do reading, letter writing journals and morning news. Document shows that there is an hour set aside every day for physical activity, also faith based activities are available to all youth. The schedule also shows that youth are given an allotted time to complete their homework, and have quite time to read approved reading books. The daily schedule is posted on each hallway and in each bedroom.

There are no exceptions to this indicator.

### 3.02 Program Orientation

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy set in place on Program Orientation. Policy number CHS/7302 was last updated on September 12, 2016 and approved by the program director.

Staff will provide all youth with a residential handbook. Staff will review all items listed on the youth orientation checklist and obtain youth's initials for each item and signature in the bottom of the page. Staff will also sign and date the form. Staff who admit youth and do the youth's intake are responsible for completing that youth's orientation within twenty-four hours of admission. Youth's orientation should include introductions to program staff and youth.

A review of five youth files documented all youth received an orientation upon entry to the shelter within twenty-four hours. Youth are given the program rules along with the behavior management strategies. A facility tour is documented to be conducted along with receiving the grievance procedures explained, room assigned, emergency disaster procedures, and abuse hotline number.

There are no exceptions to this indicator.

### 3.03 Youth Room Assignment

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy set in place on Youth Room Assignment, policy number CHS/7303, that was last updated on September 12, 2016. It was approved by the program director.

All youth are interviewed upon admission to determine the most appropriate sleeping arrangements. An alert is immediately entered into the program alert system when a youth is admitted with special needs. Staff will complete an admission packet including an admission/client orientation checklist form, physical and health screening, and CINS/FINS intake assessment form with the youth and or parent/guardian including the above referenced factors prior to making a determination regarding sleeping arrangements. Youth that are identified as LGBTQ will be made aware of alternative gender neutral sleeping options that may be available. Room assignment will be recorded in CINS/FINS intake assessment form.

A review of five youth files showed that the shelter has a form set in place to find out the youth's age, gender, history of violence, disabilities, physical size/strength, gang affiliation, suicide risk, sexually aggressive or reactive behavior, and gender identification. Documentation also showed that when a youth enters with a mental health, substance abuse, physical health, or security risks factors, an alert is immediately entered.

There are no exceptions to this indicator.

### 3.04 Log Books

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy set in place on Log books. Policy number CHS/7304 was last updated on September 12, 2016 and approved by the program director.

Logbooks will be kept in the Youth Care Staff area. The log will include documentation of all activities, which have taken place in the facility. Any information pertaining to a child should be documented in the logbook: court dates, behavior, child entering or leaving the facility. Documentation should include the date, time, a clear concise statement of what, where, when, who, and how, and will be signed and dated by the staff member making the entry. Youth Care staff and shift supervisor will read and review the log at the beginning of shift for the previous two shifts to become aware of recent occurrence problems. Highlight all major incidents and anything affecting safety and security of facility. The supervisor or designee will review the log on a weekly basis to ensure all entries are appropriate and indicate a review of the log by signing and dating in red ink and indicating such in a statement.

The shelter uses a permanent bound book to document specific activities, events, and other major occurrences. Any major incidents and anything affecting safety and security of the facility are to be highlighted. The Youth Care Staff has the logbook in their area. A review of the logbook shows that all entries are brief and legibly written in ink, incidents that include staff and youth are documented with date and time, any errors that are made in the logbook are crossed through with a clear line, no whiteout was used in the logbooks. Review of the logbook reflected that supervisors' reviews were conducted on a weekly basis, and dated and signed. Staff also review the logbook of the previous two shifts and note in the logbook that they reviewed it. Review of the logbook also showed resident counts, visitation, and home visits were documented.

There were no exceptions to this indicator.

### 3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

#### Rating Narrative

The program maintained policy and procedure number CHS/7305 to address behavior management strategies and interventions. The policy was last revised and approved on 9/12/2015 by the program director.

Upon admission each youth is to be provided a resident handbook which includes a detailed explanation of the program's behavior management system (BMS). The BMS is reviewed with each youth during orientation to the program and each youth signs to acknowledge their understanding of the BMS. The handbook along with postings in the shelter living room and each bedroom outlines inappropriate behaviors and the related consequences. Weekly re-orientation is to again include review of the BMS with the youth.

Youth are to earn points within the BMS for compliance with program rules, attitudes and interactions, school behavior as well as participation in therapeutic activities. Youth's individual point sheets are to be scored by staff prior to the daily house meeting. At least once per day, staff are to discuss both appropriate and inappropriate behaviors with each youth and are to provide positive reinforcement for appropriate behaviors and discuss consequences for any negative behaviors during a card

conference/service plan goal conference. Youth are to use their earned points at the shelter points store at designated times throughout each week and at discharge.

Staff are to utilize verbal interventions and de-escalation techniques. The procedure details prohibited techniques, inclusive of isolation, restraints, and verbal threats. Disciplinary methods are not to violate youth's basic rights of food, clothing, sleep, healthcare, school, exercise, family contact/correspondence, etc. The program is not to use room restriction for youth who are out of control, although youth separated from the population must be under constant supervision. Individual crisis counseling may be utilized if a youth's behavior is disruptive. Annual crisis intervention training is to be conducted to enhance staff skills.

The program's practice is for daily target skills sheets to be completed throughout each day with the awarding of positive and negative points for compliance, or lack thereof, with program rules/activities and behavioral expectations. Points are tallied with an expectation of achieving a minimum daily total of 80 points for youth to earn privileges. Daily points are banked and carried over as documented on the behavioral point sheet. Youth may spend points in the shelter points store to purchase tangible items during designated daily hours.

Targeted skills are revised once the youth achieves/masters each skill such as following instructions, disagreeing appropriately, and accepting criticism or consequences. Behavioral point sheets and target skills tracking sheets were reviewed. An informal interview was conducted with a youth care worker pertaining to the behavior management system. Five of five reviewed case management records and observations of staff/youth interactions documented the consistent use of the BMS in the program. Each reviewed case management record included a signed acknowledgement the youth received the shelter handbook.

There were no exceptions to this indicator.

### 3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

#### Rating Narrative

The program maintains policy and procedure number CHS/7306 to address staffing and youth supervision. The policy was last revised on 9/12/2016 and approved by the program director.

Written policy and procedures are maintained to require staffing and youth supervision in compliance with the requirement of one staff to six youth during awake hours and community activities and one staff to twelve youth during sleeping hours. The staff schedule is to be posted in a place visible and available to all staff. The program's policy requires staff to holdover until the next shift's relief arrives to replace them. The policy requires the program to make every attempt to ensure the gender of at least one staff on shift is the same gender as the youth in the shelter.

Youth location is logged utilizing the youth location chart/grip at the beginning and end of each shift, and anytime the youth enter or leave the facility, as well as upon admission and discharge. During emergency situations staff must assemble all youth for a head count and at least one staff must remain with the youth for the duration of the emergency. Staff are required to observe youth at least every ten minutes while they are in their sleeping rooms and to document each observation in the program's communication log book.

The program currently has vacancies for two full-time and two part-time shelter staff positions which impeded the program's ability to ensure overnight work shifts consistently maintained a minimum of two staff. The program has hired a new female shelter staff person who was slated to start work the week following the annual compliance review.

During the review period, the program averaged three to four overnight shifts per week covered with two staff; however the program has always been able to maintain the required ratio. The program has

creatively utilized a part-time male staff who works part-time approximately three to four days a week to provide additional coverage from 5:30 p.m. to 11:00 p.m. Additionally, the program utilized the male transportation staff to arrive early at 5:00 a.m. on days only one overnight staff was working at the shelter in order to be the second staff on-site when youth awakened in the morning.

A review of logbooks supported the staff conducted ten-minute checks on youth while they were in their sleeping rooms overnight, which exceeds the fifteen-minute requirement. The program maintains a video surveillance system which now retains video for at least thirty days. A review of the program's video surveillance log indicated shelter management staff reviewed randomly selected video footage on an average of once a week with no noted problems other than setting adjustments necessary with the program's new digital video recording (DVR).

**Exceptions:**

During the six month review period, the program consistently averaged only three to four overnight shifts per week covered with two staff. The remaining overnight shifts had only one staff covering the shift. The program has made continuous attempts to fill their vacant positions, however, the program has found it difficult to hire male staff able to pass background screening requirements who are willing to accept the hourly wage. (Another employer located near the program has a starting wage higher than that of the program.)

Logbooks for ten minute checks were not maintained in real time but rather were documented in exact ten-minute intervals for both dormitory hallways. Review of video surveillance footage for May 6, 2017 from 12:22 a.m. through 06:40 a.m. indicated staff conducted checks at greater than ten-minute intervals, varying from thirteen minutes to forty-three minutes, while the staff documented in the logbook that checks were conducted every ten minutes. Review of video surveillance footage for April 30, 2017 from 12:08 a.m. through 8:20 a.m. indicated one staff conducted checks at greater than ten-minute intervals, varying from eleven minutes to thirty-eight minutes, while the staff documented in the logbook that checks were conducted every ten minutes. Additionally on April 30, 2017, an oncoming staff indicated in the program's log book that she conducted a ten-minute check at 8:10 a.m., when the video indicated the staff signing the log had not entered the building until 8:13 a.m. and was seated in the front youth care staff office through 8:20 a.m. not having yet walked down either dormitory hallway. The CCC was contacted by this writer at 1:56 p.m. to report these incidents of possible falsification. The call was accepted and assigned CCC incident #201702603.

**3.07 Special Populations**

Satisfactory

Limited

Failed

Rating Narrative

The program maintains policy and procedure number CHS/7307 to address special populations. The policy was last revised on 9/12/2016 and approved by the program director.

The program maintains written policy and procedure to address the needs of youth to require services specific to domestic violence respite, probation respite, staff secure and domestic minor sex trafficking services.

Domestic violence respite is to be available to youth with a pending domestic violence charge who do not meet the criteria for placement in secure detention. Length of stay is to be up to twenty-one days with a planned expectation of family reunification. Service plan goals must include aggression/anger management, family coping skills to reduce the likelihood of violence in the home. After discharge, follow-up is to occur at thirty, sixty and one-hundred-eighty days.

Probation respite referrals are to be submitted by the Department for youth on probation with adjudication withheld and approval for admission must be gained from the Florida Network in advance. All case

management and counseling needs are to be addressed.

Staff secure supervision must be assigned by the court and are to include the assignment of one staff to one youth. Assessment and services planning must reflect the youth's needs and court ordered sanctions. Assignment of staff to a staff secure youth is to be documented in the log book, youth location tracking form, the census board, and highlighted on the staff schedule.

Domestic Minor Sex trafficking are to be approved for a maximum of seven days with any support beyond seven days required to seek approval on a case-by-case basis. Services are to be enhanced through direct engagement of the youth in positive activities to encourage the youth to remain in shelter.

Three of five reviewed youth files applicable for domestic violence respite included an initial case plan goal inclusive of a focus on aggression management, family coping skills, or other intervention designed to reduce re-occurrence of violence in the home.

Two youth files applicable for probation respite were reviewed, and both were found to have been referred by the youth's juvenile probation officer (JPO). The length of stay for both youth was less than fourteen to thirty days as required. There was documentation in both files to evidence that all case management and counseling needs were considered and addressed within the case plan. All other services provided were consistent with all other general CINS/FINS program requirements.

The program had no youth applicable for Staff Secure Supervision or Domestic Minor Sex Trafficking in the past year.

Exception:

Two of five reviewed case plans for youth applicable for domestic violence respite did not include goals focusing on aggression management, family coping skills, or other intervention designed to reduce re-occurrence of violence in the home. Both initial plans were developed by the same non-licensed, Master's-level counselor/case manager who does not typically complete DV case plans.

### 3.08 Video Surveillance System

Satisfactory

Limited

Failed

#### Rating Narrative

The program maintains policy and procedure number CHS/7308 to address behavior management strategies and interventions. The policy was last revised on 9/12/2016 and approved by the program director.

The program is to retain and store video for at least thirty days. The system is to record the date, time and location and must be clear enough to allow facial recognition and detail of vehicles entering and exiting the property. The video surveillance system must have a battery back-up to allow cameras to continue operation during a power outage.

The shelter is to have cameras visibly placed in general interior and exterior locations, including hallways and common areas where youth and staff congregate as well as where visitors enter and exit the program. The program's policy requires a camera to be trained upon the Pyxis medication cart and the intake room. No cameras are to be placed in the bathrooms or sleeping quarters. Only designated staff are to have access to the video surveillance system and the system is only to be viewed on-site. Supervisory review of video must be conducted weekly and documented on a review log to assess the activities of the facility.

The program had stickers posted in each program van and on the interior of the front door to the shelter to advise the facility is under video surveillance. Cameras were mounted in visible locations around the facility. No cameras were placed in bathrooms or youth sleeping rooms. The system was calibrated in order to store video for at least thirty days. The program maintains a battery back-up system to allow uninterrupted video should a power outage occur.

The program director and the residential supervisor are the only two staff designated to access the video surveillance system and it is the program's policy and documented practice to review randomly selected video on a weekly basis. A review of four randomly selected surveillance videos of the overnight shifts on April 30, May 6, May 9 and May 22, 2017 was conducted. An interview with the residential supervisor indicated reviews of video surveillance footage conducted by shelter management staff do not typically include review of hours when youth are waking, but rather are focused on hours in the middle of the night. Documentation of management review of video documented the date the video was reviewed and a span of days of the videos reviewed rather than the specific dates and time periods of the video reviewed.

There were no exceptions to this indicator.

## Standard 4: Mental Health/Health Services

### Overview

#### Rating Narrative

Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The Residential Supervisor and/or CINS/FINS Counseling Supervisor is notified immediately if risks and/or alerts are present. Staff follows through with the recommendations regarding placement and appropriate supervision is provided by the direct care staff. This information is documented in various places such as the census board, youth alert form, and in the program logbook. The agency also uses the Evaluation of Suicide Risk (EIDS) on all youth admitted to the shelter. The qualified mental health professional is the only staff person with the authority to determine the suicide risk status of the youth. The clinician completes a full Assessment of Suicide Risk (ASR) on all youth on close observation status.

Youth admitted to the shelter with prescribed or over-the-counter medication will surrender those medication to staff during admission. The shelter uses the Pyxis Med-Station 4000 Med Cabinet for the provision of prescribed medication to youth. All staff in the facility received regularly healthcare and mental health trainings. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication. An approved staff is scheduled on each shift and their name is highlighted on the staff schedule. Medication records are maintained for each youth and stored in the youth's file on the Medication Log Record (MLR).

#### 4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy in place for Healthcare Admission Screening. The policy number is CHS 7401 and was last updated on September 12, 2016.

During the admission process, non-health care staff will complete an initial physical health screening form with the youth. If present on premises, the staff nurse will conduct the health screening. Staff doing the intake will review with the youth their past and current medical history. When a nurse comes on shift, new intakes are reviewed within five business days and documentation of such is noted in the youth file.

During the initial physical and mental health screening, youth are screened for serious conditions that may be encountered in the shelter such as diabetes, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, pregnancy, or suicidal ideation/mental health concerns and head injuries occurring during the previous two weeks. For all youth with any of the above conditions there is a referral process in place. The parent/guardian shall be contacted to identify established guidelines for daily medical care and routines. If any chronic conditions are identified that indicate a need for medical follow-up, staff will document discussion of this need with the parent/guardian in the medical section of the youth's file. If a youth has not been treated for a condition, the intake staff will follow-up with the parent/guardian, to have the parent schedule a medical examination as soon as possible and document communication. The youth will be transported by the parent/guardian to any scheduled medical appointments.

There were five youth files reviewed for Healthcare Admission Screening. In all five files the CINS/FINS Intake Assessment Form was completed at admission. In two of the files reviewed the youth were taking medications and those were documented on the Client Prescription Medication Form. Two of the youth had allergies documented. None of the youth had any type of chronic health condition that required monitoring or follow-up care but there are procedures in place if it is needed. Three of the five Health Screening Forms were reviewed and signed by the RN within five days. The remaining two files still had two days and one day left for the RN to review the screening.

There were no exceptions to this indicator.

#### 4.02 Suicide Prevention

Satisfactory

Limited

Failed

##### Rating Narrative

The shelter has a policy in place for Identification of Suicide Risk in Shelter/Prevention. The policy number is CHS 7402 and was last updated on September 12, 2016.

All youth admitted to the shelter will immediately be screened using the Evaluation of Suicide Risk Among Adolescents. The Evaluation of Suicide Risk Among Adolescents is completed by YCW staff. If the youth answers a minimum of five “yes” responses on the Risk Factor Criteria Area 2, or one “yes” response on Risk Factor Criteria Area 1, they are immediately placed on suicide precaution status. The agency tracks all youth on observation status every ten minutes. The staff then informs the Licensed Clinical Social Worker (LCSW) of the youth’s status. The LCSW is the only staff person with the authority to determine the suicide risk status of the youth. The LCSW completes a full Assessment of Suicide Risk (ASR) on all youth on suicide precaution status. The shelter utilizes two levels of supervision: one to one supervision and constant sight and sound supervision.

There was one applicable file of a youth placed on suicide precautions since the last on-site review. The CINS/FINS Intake Assessment form and the Evaluation of Suicide Risk Among Adolescents were both completed at admission and documented positive “hits” requiring the youth to be placed on suicide precautions. This youth was admitted on a Saturday and the client was seen and assessed by the LCSW on Monday morning. There were ten minute observations maintained on the youth until removed from suicide precautions. The LCSW completed an ASR on the youth and the youth was placed on standard supervision. The shelter has a daybed in the dayroom that youth must sleep on when on suicide precautions during the overnight hours.

There were no exceptions to this indicator.

#### 4.03 Medications

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has a policy in place for Medications. The policy number is CHS 7403 and was last updated on September 12, 2016.

The policy has detailed procedures for admission, verification of medication, administration of medication, storage of medication, inventories, discharge, and disposal of medications. This policy covers the requirements for medication distribution in accordance with the DJJ Health Services Manual.

The shelter has two Registered Nurses that are on-site Monday through Friday after 5:00 p.m. for approximately two hours. The RN, the Residential Supervisor, and the Program Director are listed as the Super Users for the Pyxis Med-Station. All staff employed in the shelter are trained to use the Pyxis Med-Station and administer medication. The RN trains all new hires on using the Pyxis-Med Station. Medication administration training is completed through on-line training during the staff’s first 90 days of employment.

All medications are stored in the Pyxis Med-Station. Drawer one is over-the-counter medications and drawer two is prescription medications. Drawers three, four, and five are empty. There is a refrigerator with a lock on it located in the pantry in the kitchen for medications requiring refrigeration. At the time of the review there were no medications requiring refrigeration.

Controlled medications are inventoried each shift by two staff members and non-controlled prescription medications are inventoried at least once each day. Over-the-counter medications are inventoried weekly and when given. The shelter only has three over-the-counter medications that are given out: Tylenol, Motrin, and Calamine Lotion. The only sharps the shelter keeps are disposable razors. At the time of the review there were six razors in the box in a locked cabinet. The razors were inventoried weekly for the last six months. For the current weekly inventory, the count was off by one. It appears a razor was disposed of and not documented correctly.

The shelter uses a Medication Log Record (MLR) for each youth on medication. The MLR documents the youth's name, a picture of the youth, allergies, diagnosis, physician information, date of birth, date started, if it is a controlled medication, the medication, directions, possible side effects, signatures and initials of staff. There were three youth files reviewed, one open and two closed, to verify medication administration. All three files documented the medication was verified by contacting the local pharmacy. All three files had MLRs for each medication the youth was taking. The MLRs were filled out completely and documented all medications were given at prescribed times. The RN dispenses evening medications and the staff dispense morning medications.

The RN does not currently have access to the Knowledge Portal to run reports monthly. The Residential Supervisor is the only person with access; however, is unfamiliar with the Knowledge Portal and what reports to run. The Residential Supervisor reported any discrepancies are cleared out by the end of the staff members shift.

**Exceptions:**

The current weekly inventory for the sharps was off by one. It appears a razor was disposed of and not documented correctly.

The shelter is not currently running any monthly reports from the Knowledge Portal.

**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. The policy number is CHS 7404 and was last updated on September 12, 2016.

All youth are screened on admission for physical, mental health, and substance abuse needs. After identifying a youth as needing special medical/mental health attention, intake staff will place an identifying marker on the youth's name on the room assignment/census board. For those youth with medical/mental health needs, a medical/mental health alert sticker will be placed on the outside of the youth's file. A red general alert form is the first page placed in the youth's file indicating specifics of the alert. Intake staff will make specific highlighted entries in the logbook describing the particular medical conditions, medications, and allergies. Staff will check the census board at the beginning of their shift and review the chart and medication log for those youth identified as having a medical condition in order to become familiar with said conditions and possible emergency situations.

There were five open youth files reviewed. All alerts identified during the screening process were documented on the alert form in the front of the youth's file. All files had a red alert sticker on the front of the file indicating an alert. Alerts were also documented in the shelter log book. There is an alert board located in the mail room. All youth in the shelter are documented on this dry erase board. If the youth have any alerts a red check mark is next to the youth's name in the alert column. Staff review this alert board when coming on to shift and can then find additional information regarding the youth's alert in the youth's file. All youth in the shelter who had alerts were appropriately documented on this board.

There were no exceptions to this indicator.

#### 4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has a policy in place for Episodic/Emergency Care. The policy number is CHS 7405 and was last updated on September 12, 2016.

All direct care staff are trained and certified in first aid and CPR. Staff will be trained in emergency situations requiring more than first aid and CPR. The AED, knife-for-life, and wire cutters and first aid kits are securely stored in appropriate locations. Parental notification takes place when any youth is injured, regardless of the severity, providing parents with the option to seek further medical attention elsewhere. All instances of first aid and emergency care are documented in the log book, the youth's file, and on an internal incident report. Upon return to the shelter from seeking outside medical treatment, verification of medical clearance, discharge instructions, and follow-up care will be provided to staff and included in the youth's file.

There have been four instances in the last six months of youth being transported off-site for emergency medical. All four incidents were reported to the CCC. There was documentation in all four cases that the youth's parent was notified. Follow-up instructions were documented when the youth returned to the shelter. All four incidents were documented in the logbook.

The shelter has completed seven Episodic/Emergency Drills in the last six months. The drills were completed on various shifts. Drills consisted of a burn, a snake bite, an eye wound, a spider bite, youth self-harm, a chemical spill, and a tornado. The drills included a staff response, debriefing notes, supervisory review, and a corrective action plan.

The shelter has four first aid kits, two located inside the shelter and two are for the vehicles. The first aid kits are inventoried weekly by the overnight shift. These inventories were reviewed for the last six months. The inventories document what is inside the first aid kit and what needs replenishing. There is a knife-for-life and wire cutters located in a locked box in the mail room of the shelter.

There were no exceptions to this indicator.