



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CHS Treasure Coast, WaveCREST

on 11/18/2015

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 | Satisfactory |
| 1.05 Analyzing and Reporting Information | Satisfactory |
| 1.06 Client Transportation | Satisfactory |
| 1.07 Outreach Services | No rating |

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

Rating Definitions

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

| | |
|-------------------------|--|
| Satisfactory Compliance | No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated. |
| Limited Compliance | Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically. |
| Failed Compliance | The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery. |

Review Team

Members

Marcia Tavares, Lead Reviewer, Consultant-Forefront LLC

Gabriela Medina, Regional Monitor, Department of Juvenile Justice

Gregg Miller, Executive Director, Lutheran Services Florida



Joel Rivera-Rosado, Counselor II, Youth and Family Alternatives

Mary Williams, Program Director, Center for Family and Child Enrichment

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 0 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 3 Clinical Staff | 1 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 0 Food Service Personnel | 1 Other |
| <input type="checkbox"/> DMHA or designee | 0 Health Care Staff | |

Documents Reviewed

- | | | |
|---|--|---|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input 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 | 3 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 3 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 8 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 6 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 3 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 9 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input checked="" 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

- 4 Youth 4 Direct Care Staff 4 Other

Observations During Review

- | | | |
|--|--|--|
| <input type="checkbox"/> Intake | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input type="checkbox"/> Staff Supervision of Youth |
| <input 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 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 checked="" type="checkbox"/> Meals |
| <input type="checkbox"/> Medical Clinic | <input 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

The CHS Treasure Coast Division has been continuously accredited since 1982 by the Council of Accreditation (COA), demonstrating its commitment to the highest quality of care and service while adhering to the toughest administration standards. The programs in the Division operate various services to more than 11,000 kids and families annually in the Okeechobee/Treasure Coast area. Services include:

- Adoptions
- Child In Need of Services /Family In Need of Services (CINS/FINS)
- Child Protection Team
- Child Safety/Dependency Case Management
- Transitional Living Program
- Safe Place
- Over the past year, CHS WaveCREST has made significant improvements in the shelter facility and programming, and has received recognition for its performance. These accomplishments are summarized as follows:

Facility Improvements

Dorm and Shower Room/Stalls: The shower stalls and bathrooms were renovated with fiberglass shower enclosures and new flooring. New sinks, toilets, cabinetry, mirrors, and addition of a handicap accessible bathroom as well as replacement windows were included in the renovations. Funding for the renovations was made possible through the agency's partnership with the local Continuum of Care as a part of their larger proposal.

Dining Room/Living Room Area Floors: The flooring in these living spaces were worn and in need of replacement. As a result, the living and dining room flooring was replaced with new tiles similar to those used to upgrade the shower areas.

New Alarm System: The program has added a camera in the laundry room where the medication system is currently located.

New mattresses were furnished for all of the beds in the shelter.

An **AED unit** was added to the facility.

Programming Improvements

Why Try Group: Staff were trained in Level I and II of Why Try, a strength-based curriculum to help youth overcome their challenges and to improve outcomes in the areas of truancy, behavior, and academics. The program was piloted over the summer and will roll out into the community. Educational and Life Skills videos were purchased for implementation into groups.

Addition of Afterschool Computer Lab to increase youth's access to online school and various school platforms used for homework, electronic textbooks etc.

Vehicle Video Cameras were purchased on each shelter van and are in the process of being installed. The recordings will allow for video and audio monitoring of the driver and passengers.

Program Highlights

- The agency received 211's Exceptional Non-Profit in Collaboration Award for demonstrating the ability to make a positive change in the community by creating lasting partnerships with other organizations.
- The Shelter Program Manager was presented with the Leadership Award of 2015 by Florida Juvenile Justice Association.
- WaveCREST was awarded the 2015 Program of the Year Award by the Florida Network of Youth and Family Services.

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 Program Manager, a Residential Supervisor, a licensed Clinical staff, and an Outreach Counselor Supervisor. Shelter staff includes: a Secretary, Group Living Manager, seven fulltime Youth Care Staff (YCS), and five part time/relief Youth Care Staff. The counseling/case-management component has five counseling positions. At the time of the quality improvement review, the shelter had one (1) vacant fulltime Counselor and three (3) vacant Relief YCS positions.

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.

The provider has a revised Emergency Response Plan showing a current revision date and a Universal Agreement for Emergency Disaster Shelter signed by the Executive Director is also in force.

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 25, 2015, that address the requirements of the indicator for background screening of employees and volunteers. The provider's 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.

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 eight background screening files were reviewed for four new hires, three interns, and one employee who was eligible for a 5-year background screening during the review period. The four new personnel had timely background screenings completed prior to their hire dates. Similarly, the three interns received an eligible screening result prior to their volunteer service start dates. The employee who was eligible for a 5-year background screening had the re-screening conducted during the required timeframe prior to their 5-year anniversary.

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 14, 2014 and most recently on November 18, 2015.

1.02 Provision of an Abuse Free Environment

Satisfactory Limited Failed

Rating Narrative

The program has a comprehensive policy, last updated August 25, 2015, that address the requirements of the indicator for providing an abuse free environment. The policy requires the prominent posting of the Abuse Registry phone number. Postings of the Abuse Hotline number were evident in numerous locations during the tour including posting on a board in each youth's bedroom, the intake office, and the lobby. The program's policy specifically complies with DCF and DJJ policies related to abuse reporting and require program employees and volunteers to

report all known or suspected cases of abuse and or neglect to the Florida Abuse Hotline. Anyone, including paid staff and volunteers, are expected to abide by the agency's rules of conduct that foster an abuse free environment and prohibit intimidation, physical abuse or force. During orientation, staff is issued a copy of the agency's Code of Conduct that outlines its policy and staff's responsibility to ensure the care, safety, and well-being of youth in their care.

The program also has a grievance policy, #7308, in place that requires families and youth to be informed of their right to grieve and youth acknowledge their understanding of the process by their signature at intake. The policy describes the grievance process from the informal to Program Director phase but does not fully address item #3 of the indicator that prohibits direct care staff from handling grievances unless assistance is required by youth. During the tour, it was observed that the program maintains blank grievance forms above the grievance box on a wall in the dining area. Additionally, Rights and Responsibilities are also posted in each youth's bedroom and in common areas accessible to youth.

The program provided a notebook of all compiled grievance forms filed in the facility. Since the last QI Review in November 2014, the program has had seven (7) grievances. All seven grievances were resolved at the Supervisor's phase in a timely manner. The youth acknowledged acceptance of the resolution via signature in all but one of the seven grievances. Two of the grievances were made regarding two separate staff's verbal tone/volume when speaking with youth. The supervisor addressed the grievances by meeting with the staff. During the QI visit, the Residential Supervisor was in the process of writing up a Disciplinary Action for one the Youth Care Staff who was listed in one of the above stated grievance.

Four youth were surveyed for this review; three of the four youth indicated that they knew the Abuse Hotline was available to them and two knew where the number was located in the facility. None of the youth surveyed made attempts to call the Hotline. All four youth stated that staff is respectful to them and no adult had ever used threats or profanity towards youth. The grievance process was known to all four youth surveyed. The facility was observed to be free of graffiti and all of the youth surveyed indicated that they feel safe at the facility.

Four staff members were surveyed for this review. Two of the four indicated that the working conditions were good and two stated it was fair. All four described appropriate procedures to facilitate youth calls to the Abuse Hotline. None of the four staff surveyed have ever observed a co-worker telling a youth they could not call the Abuse Hotline. One of the four staff has observed a co-worker using profanity when speaking with a youth but none has observed their co-workers using threats of intimidation, or humiliation when interacting with a youth.

Exceptions:

The grievance policy (#7308) describes the grievance process from the informal to Program Director phase but does not fully address item #3 of the QI indicator that prohibits direct care staff from handling grievances unless assistance is required by youth.

Four youth were surveyed for this review; One of the four youth indicated s/he did not know the Abuse Hotline was available to them and two stated they did not know where the number was located in the facility.

One of the four staff surveyed has observed a co-worker using profanity when speaking with a youth.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The program has an established written policy and procedure, last approved August 25, 2015, for Incident Reporting. The policy and procedures require compliance with the Florida Department of Juvenile Justice (DJJ), Department of Children and Families/Identified Community Based Care Agency, and Children's Home Society. Per the provider's policy, reportable incidents are to be reported to the DJJ Central Communication Center (CCC) as soon as possible, and no later than two hours of the incident/gaining knowledge of the incident.

CHS maintains information about incident reports via a paperless computer database system called AirsWeb. A log of all incidents which occurred and recorded in the AirsWeb system or the period May-November 2015 was printed and provided to the Reviewer. The program had 26 total incidents included in their AirsWeb system log for the review period. Ten of the incidents were called in to the CCC and six of the ten were accepted. The six incidents accepted were: contraband (2), offsite medical transport (2), youth arrest (1), and medication error (1). However, two of the incidents were acknowledged by CCC to be non-reportable incidents (11/15/15 and 5/29/15) although they were accepted by CCC for information only.

All four reportable incidents were called into the CCC within the two hour time frame per the program's policy and procedures. The program provided documentation of follow-up with the CCC for one applicable incident. A review of the remaining 20 incidents on the database log for the preceding six month time period indicated that none of the other incidents were reportable to the CCC due to either not being a reportable incident type.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The program has an approved (9/22/2015) comprehensive training policy and procedures, #7104, to ensure the provision training in necessary and essential skills required for staff to perform specific job functions. In addition to its policy and procedures, the provider has an annual Training Plan for FY 2015-2016 that describes its protocol for complying with the training requirements.

Training is provided through various means including online using the agency's Learning Management System (LMS), the Florida Network, 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 exceeds the requirements of the indicator and has an established procedure requiring certain trainings to be completed by new hires within the first 90 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.

The training files of three new hire employees were reviewed. Two of the three new hires have exceeded the 80 hours of training required and the remaining one is 1 hour short of completing the 80 hours. The majority of training topics required were also completed by the three staff.

Two of the three in-service training files reviewed exceeded the 40 hours required annually and all three had completed the required refresher CPR/First Aid training and two of three completed the Fire Safety Training required for in-service staff annually. In addition, as of the date of the QI review, two of the three staff had also completed all of the recommended trainings.

The provider's Licensed Clinical Staff is the only staff used to conduct an Assessment of Suicide Risk (ASR). Since non-licensed staff do not complete the ASR, the training requirements associated with this indicator are not applicable for the provider. The provider's policy and procedure reflects the aforementioned policy.

Overall, the provider does an excellent job in ensuring staff receives the training required as well as those necessary to serve its at-risk youth population. Training records are well maintained and consistently documented with certifications, sign-in sheets, handouts, etc. The annual training plans developed between the staff and the program supervisor ensures accountability and delivery of appropriate training for each staff.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

CHS has a written policy establishing collection of data from several sources to identify patterns and trends for case record reviews, incidents, accidents, grievances, customer satisfaction surveys, outcome data, and monthly review of Netmis data reports. The program has a comprehensive CHS Quality Management structure. The agency's provides procedures for data collection, aggregation of review and analysis, communicating results, using data for implementing improvement, and assessment of the effectiveness of the QM process.

The program has a designated Quality Management Specialist (QMS) who is responsible for the implementaton and oversight of its CQI program. The 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.

Quarterly case record reviews are conducted by the program clinical staff as directed by the program supervisor and are due on the last day of the 3rd month of each quarter. A copy of the program's schedule for records review was provided to this reviewer. Upon completion of each record review, the QMS aggregates the results and provide a copy of the aggregated report is saved on shared drive and shared with program supervisors to discuss themes, trends, and any areas of concern. Program supervisors include review of these data in their monthly staff meetings, as documented by the agendas and minutes of each meeting, which includes training and remediation where appropriate. The QMS also follows-up at a later date to spot check specific files to verify completion of the corrective actions.

The program's Safety Committee is responsible for reviewing incidents and accidents, performing safety checks and fire drills, and making recommendations to management on a monthly basis. Each program site has a representative who sits on the Safety Committee. The safety committee meets on the third Tuesday of each month by phone. Minutes from each meeting are produced and provided to committee members (including the QMS) and the executive Director (ED). The Division Safety Committee Coordinator discusses safety concerns and suggestions with the ED monthly and follows up with the QMS as needed. The QMS will follow up with the ED and program supervisors as needed to ensure division safety.

Consumer grievances are documented in AirsWeb, submitted to program supervisors and reported to the QMS on a monthly basis via the PPR. Consumer surveys are administered twice a year during the second and fourth quarters. The QMS addresses consumer surveying via email and at a management team meeting and notifies the program supervisors of the outcome of the surveys. The surveys are aggregated by the QMS and provided to supervisors, DPO, and ED.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

CHS WaveCREST has a transportation policy to ensure that best practice is considered in all situations where youth are transported by staff and to avoid possible situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth. The best practice to prevent such situations is to have a 3rd party present in the vehicle while transporting a client.

Approved agency staff drivers are staff approved by administrative personnel. The third party may be another direct care staff, volunteer, intern, clinical or administrative staff or other youth. 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. The reviewer was given the log for review. Each driver of vehicle will log out the keys to the vehicle and take with them a first aid kit when providing transportation. The driver's log is maintained in a binder in the vehicle and consists of driver/staff's name, date and time, mileage, number of passengers, purpose of travel and location. In the event that a 3rd party cannot be present for transport, the client's history, evaluation and recent behavior is considered as well as the transporting staff's work performance and history, before management consents to transportation arrangements. During transportation time, an open line will be utilized by staff calling the shelter from the vehicle. Documentation was reviewed on the vehicle log for arrangements to include the supervisor approval and use of open line.

The program has 2 cameras installed in both agency vans, including audio and video to capture in the absence of the 3rd party and will be reviewed periodically for compliance.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

CHS WaveCREST's outreach services is diligently conducted by the program on an ongoing basis to increase public and community awareness. CHS participates on each local county council and the DJJ Circuit 19 Advisory Board to ensure prevention programming of

CINS/FINS service are represented. Additionally, outreach include youth and families through presentations in schools, community agencies and resources, events, fairs, law enforcement, and businesses as well as dissemination of printed materials informing the community of CINS/FINS as an effective prevention and intervention service.

Interagency agreements are utilized by CHS to build strong community partnerships and collaborations, ensuring youth and their families served receive appropriate services including shelter, medical, educational, therapeutic, and other supports that are identified in the service plan.

The reviewer reviewed binders on Outreach events 2014-2016, Interagency Agreements, Detention Reviews, and Community meeting participation.

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, educational assistance, and a newly implemented 8-week parenting support group. 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 (4) counseling positions and a supervisor. 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 and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last updated 9/22/15 and was signed by the program director.

A total of three Residential and four Non-residential files were reviewed. All files reviewed indicated eligibility screening was completed within 7 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.

2.02 Needs Assessment

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last updated 9/22/15 and was signed by the program director.

A total of 3 Residential and 4 Non-residential files were reviewed. All Residential files reviewed indicated the Needs Assessment was initiated within 72 hours of admission. All Non-residential files reviewed indicated the Needs Assessment was completed within 2-3 face-to-face contacts after initial intake. All files reviewed included a supervisor review.

2.03 Case/Service Plan

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last updated 9/22/15 and was signed by the program director.

A total of 3 Residential and 4 Non-residential files were reviewed. All files reviewed indicated a case/service plan was developed within seven working days following completion of assessment. Two (2) of three (3) Residential files indicated case/service plan goals were individualized and prioritized need(s) and goal(s) identified by the Needs Assessment. All Non-residential files indicated case/service plan goals were individualized and prioritized need(s) and goal(s) identified by the Needs Assessment.

One (1) Residential file and 4 Non-residential files required case/service plan review every 30 days. All files documented reviews were completed within 30 days. One (1) Non-residential file had late signatures for case/service plan review, but documentation supported attempts to reach parent/guardian to schedule appointment, and the reviews were completed over the phone within the 30 days.

Exception:

One exception was noted. One (1) of three (3) Residential files provided general case/service plan goals but did not specifically address domestic violence and runaway behavior identified in the Needs Assessment.

2.04 Case Management and Service Delivery

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last updated 9/22/15 and was signed by the program director.

A total of 3 Residential and 5 Non-residential files were 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. Two (2) files provided referrals for substance abuse, three (3) files provided referrals for mental health, and three (3) files provided referrals for both mental health and substance abuse.

One (1) Non-residential file needed a referral to the case staffing committee and the referral was made. Documentation indicated staff accompanied youth and parent/guardian to court hearings and related appointments as needed. All Non-residential files provided case monitoring.

2.05 Counseling Services

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last updated 9/22/15 and was signed by the program director.

A total of 3 Residential and 4 Non-residential files were reviewed. All files reviewed indicated counseling services were received in accordance with the case/service plan. All Non-residential files and 2 of 3 Residential files reviewed addressed the presenting problems in the needs assessment, case/service plan, and case/service plan reviews. Group counseling was provided 5 or more days per week for youth in shelter care.

All files indicated case notes were maintained for all counseling services provided and documented youth's progress. All files indicated an ongoing internal process for clinical reviews of case records and staff performance.

Exception:

One (1) Residential file did not include counseling services to address the presenting problems of domestic violence and runaway behavior that were identified during the assessment process.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last updated 9/22/15 and was signed by the program director.

A total of 3 Non-residential files were reviewed. None of the files indicated parent/guardian initiated staffing. All 3 files indicated the family and committee were notified no less than 5 working days prior to the staffing.

All 3 files indicated the local school district representative and CINS representative were in attendance. Two (2) of three (3) files indicated a new or revised plan for services was provided. All files indicated a written report of the staffing's recommendations were provided to the parent/guardian within 7 days of the case staffing meeting.

All files indicated the program works with the circuit court for judicial intervention, and the case manager/counselor completed a review summary prior to the court hearings.

Exception:

One of the case staffing files reviewed did not have a revised service plan after the case staffing was held, showing the committee's recommendations.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last updated 9/22/15 and was signed by the program director.

A total of 3 Residential and 4 Non-residential files were reviewed. All files reviewed were marked "confidential" and kept in a secure room and locked in a file cabinet. All records that were transported were locked in an opaque container that was marked "confidential." Youth records were maintained in a neat and orderly manner.

No exceptions were noted.

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 and the license is current through February 28, 2016. 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. Despite deficiencies due to the aging of the facility, during the tour, the facility was found to be in good working condition and the furnishings in good repair. Recent improvements to the facility include the renovations of the bathrooms with new tiled flooring, cabinets, toilets, and shower stalls. New flooring was also added to the dining and living room areas.

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 on Shelter Environment that was last reviewed and updated on October 9, 2015. The physical layout of the shelter includes a living and dining area centrally located with the male and female dormitory on either side. There are a total of six (6) dorm rooms, four house two (2) beds, and two (2) of the dorm rooms have a bunk bed with an additional twin bed, allowing the program to accommodate more youth of a particular gender when needed. The front living room area housed a bed specifically for suicide watch and medication observation. Also located in the central area is the intake office and laundry room. The laundry area houses the PYXIS Medication system. The facility has a computer lab with 6 computers located in the living area. Wave C.R.E.S.T. also has an insulated and air conditioned back porch with a dedicated exercise area consisting of 2 stationary bikes, 2 treadmills, an elliptical machine and a weightlifting bench. During the tour the shelter appeared to be clean and well maintained considering the age of the building. Bathrooms were clean and functional. Sleeping quarters and common areas were well maintained and furniture was in good repair with no visible signs of graffiti. The shelter has a disaster plan in place that was updated in April 2015 and includes all components consistent with the Florida Network policy and procedure manual requirements. The shelter documented quarterly inspections of all fire safety equipment on 1/8/2015 and by Fire Equipment Services of St. Lucie, Inc. The same company completed an annual fire safety equipment and fire extinguisher inspection on 8/14/15. An annual fire safety inspection was completed by the local Fire Marshall on 11/5/15. Semi-annual hood inspections were completed on 12/1/14 and 6/24/15 on the overhead hood system in the kitchen. All above inspections were rated as satisfactory. An annual residential group care combined with a food service inspection was completed by the Department of Health on 10/12/2015 also with a satisfactory rating. The shelter conducted fire drills, one on each shift, every month for the past six months. There was also a mock emergency drill documented on each shift, each quarter. The drills included: a first aid drill, a suicide attempt, weather related emergency, a baker act drill, a chemical spill drill, and a heat exhaustion drill. The shelter has a two-week cycle menu posted that is followed and was last reviewed by a licensed dietician in 2012. All first aid kits were fully stocked and are inventoried and re-stocked on a weekly basis by the overnight shift. The overnight shift also inventories all chemicals on a weekly basis; a MSDS is maintained on each chemical and all chemicals are securely stored in the laundry room when not in use. A weekly physical plant/safety inspection/housekeeping and sanitation checklist is completed by the Residential Supervisor. The shelter has a daily activity schedule in place. Youth are engaged in structured activities seven days a week with minimal idle time. Youth are able to participate in faith based opportunities and are provided down time for reading and homework.

The program has a video recording system and added cameras to cover the Pyxis Medication system and intake room. Per the Program Manager, the additional cameras are utilizing more memory of the video recording system which has shortened the number of review days to 20 days.

Exceptions:

During a review of the parking lot, one personal car door (Buick Lasabre) was unlocked.

The door in the kitchen leading to the outside was consistently unlocked.

3.02 Program Orientation

Satisfactory Limited Failed

Rating Narrative

The agency has a policy on Program Orientation that was last reviewed and updated on October 9, 2015. The shelter provides each youth an orientation within twenty-four hours of admission. Each youth is to receive a Resident Handbook and complete the Youth Orientation Checklist. Staff and youth are to initial each item on the checklist and sign the bottom. Each youth is to review and sign a safety agreement stating they will alert staff of any suicidal thoughts. The orientation includes introductions to staff and youth. A re-orientation is to occur weekly with all youth.

There were six youth files reviewed of which 3 were open and 3 were closed. All six youth were provided an orientation to the shelter within twenty-four hours of admission. An orientation checklist was completed that documented all required topics were covered, and was initialed and signed by the youth and staff. As part of the orientation process all youth were assigned to a room. None of the youth documented any suicidal issues therefore an alert for suicide was not required. There was also documentation in each file that the youth and guardian received a Resident Handbook. This also covered all topics discussed during the orientation process. Each youth signed a safety agreement, as required per the shelter's policy, stating they will alert staff if they have suicidal thoughts. At the end of the orientation process each youth was given a tour of the facility and introduced to program staff. Staff conducts a weekly re-orientation with all youth. This was confirmed on daily schedules provided for review.

3.03 Youth Room Assignment

Satisfactory Limited Failed

Rating Narrative

The agency has a policy on Youth Room Assignment/Classification that was last reviewed and updated October 19, 2015. Staff completes an admission packet including an Admission/Client Orientation Checklist Form, Physical and Health Screening, and a CINS/FINS Intake Assessment Form with the youth and guardian including all factors required in making a determination regarding sleeping arrangements. The room assignment is recorded on the CINS/FINS Intake Assessment Form. Any applicable alerts are entered into the shelter's alert system which is a red form located in the front of the youth's file documenting the appropriate alerts which are also documented in the logbook at admission. It is noted next to the youth's name on the alert board in the shelter that the youth has an alert. Staff then refers to the logbook or youth file to find out more information on the alert.

There were three youth files reviewed and all three files documented the CINS/FINS Intake Assessment was completed at admission and the youth were assigned to a sleeping room. All required factors were addressed when assigning the youth to a room. Any alerts were documented on the red alert form located in the front of the file. Alerts documented on the red form in the files reviewed correspond to information documented throughout the youth's file. The alert board, located in the staff work area, was also observed. The three youth were documented on the board and the two applicable youth had "alert" checked next to their name, as per shelter policy. The logbook was also reviewed and there was an entry made in the logbook, for each youth file reviewed, at admission with all applicable alerts documented.

3.04 Log Books

Satisfactory Limited Failed

Rating Narrative

The agency has a policy in place for Logbooks that was last revised October 9, 2015. The shelter uses a permanent bound book to document daily activities, events, and other major occurrences. Any major incidents and anything affecting safety and security of the facility are to be highlighted. Each entry in the logbook is preceded by a code which indicates the type of entry being made, for example, "SR" means Shift Report, "BD" means Bed Check, "SI" means Sign In, "SO" means Sign Out, and so on. This system of placing a code before each entry was very effective when trying to locate certain types of entries in the logbook.

Entries in the logbooks were brief, legible, and all written in black ink. Safety and security issues, new intakes, daily activities, mental health

concerns, room checks, and shift reviews were all documented in the logbooks. All entries made in the logbook were ended with the staff signature. The date was documented at the top of each page. Major incidents and safety and security issues were highlighted in yellow. A shift review is completed at the end of each shift giving the on-coming staff a summary of the previous shift. All staff sign out of the logbook at the end of their shift. There was documentation in the logbooks that reviews by the supervisors and staff are happening on a consistent basis. All staff working the shift consistently signed in the logbook and documented a review. The Residential Supervisor reviewed the logbook at least once each week. When this review occurred the Residential Supervisor initialed and dated the top of each page reviewed and then made an entry in the logbook that is was reviewed. Any corrections or recommendations were documented in the entry or throughout the logbook, on pages reviewed, in red ink. All entries made by the Residential Supervisor were done so in red ink making them easy to locate. It was also evident by the way the reviews were completed that each page and entry in the logbook had been reviewed by management.

3.05 Behavior Management Strategies

Satisfactory Limited Failed

Rating Narrative

The agency has a policy on Behavior Management Strategies/Interventions last reviewed and updated October 9, 2015. The system is designed to foster accountability and compliance with the program's rules and expectations. Points are earned for positive behaviors. A point sheet is used to track the youth's behavior while in the shelter. At intake, a youth is entered on Orientation Status and remains so for the initial twenty-four hours in the shelter. During Orientation Status a youth will be able to earn a total of 100 points with the display of desirable behaviors. Points will be allotted on a shift-by-shift basis and determined solely by the youth's behavior. Completion of the Orientation Status will lead the youth to Consumer Status and the youth will begin to earn positive or negative points based strictly on the behaviors exhibited.

Throughout the youth's stay in the shelter, a daily point tabulation and behavior check will occur. A youth who scores better than 80 points in a day will not only earn those associated daily privileges but an additional ten bonus points. Bonus points are only used to purchase items from the point store and do not affect daily privilege. A youth scoring 90 points or better will have total privilege and earn the additional twenty bonus points. Any youth having a fully successful day earns thirty-five bonus points. Points in excess of 100 can be "cashed in" at the point store or "banked" for later purchases. Subsequent days will begin following Service Plan Goal Conference. During this nightly period a youth may earn forty points for appropriate bedtime behavior and a quiet night.

There were three youth files reviewed and each file contained a daily Target Skills sheet. Points are earned for different activities throughout the day. The sheet documented how many points were earned for each activity, any negative points accumulated, the total points earned for the day, and the total "banked" points that can be used in the point store. Each file also contained a Behavioral Point Sheet which calculated all points earned for the week and documented all "banked" points. In the three files reviewed it appears that positive rewards and negative consequences are given on a consistent and fair basis. There were no issues with the behavior management system; it appears to be working well. Six files reviewed indicated rewards and consequences were given on a consistent and fair basis. The youth were able to appeal decisions regarding points being taken away, which are then reviewed and mediated by the program supervisor.

3.06 Staffing and Youth Supervision

Satisfactory Limited Failed

Rating Narrative

The agency has a policy on Staffing and Youth Supervision that was reviewed on November 18, 2015.

Staff schedules were reviewed for the month of November 2015. During the sleep hours, the shelter consistently met or exceeded ratio requirements and there was always at least one male and one female staff on duty. The shelter completes ten minute checks of the youth during the sleeping hours, exceeding the fifteen minutes requirement.

The checks are documented in the logbook. The checks reviewed in the logbooks were consistently every ten minutes every night for the past six months. The reviewer viewed the tapes selected for November 4 & 11 for the sleep shift. The staff were male and female and bed checks were consistent within 8 to 11 minutes for checks during the hours of 1:30 am to 7:30 am. The reviewer also reviewed two other months (April & July) to verify male and female staff working the shifts. Male and female staff were listed on the log.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

Special populations, Domestic Violence Respite services, Probation Respite, Staff Secure and Domestic Minor Sex, are addressed according to the needs of the youth and contract compliance. Trafficking will meet the requirements of the Florida Network. CHS WaveCREST has 325 allotted number of domestic violence bed placements each fiscal year. The reviewer viewed the approval form from Florida Network in the three files reviewed. The forms were placed in the legal section of youth's file along with JJIS and face sheet. The Domestic violence placement verification files were noted and the JJIS intake assessment was signed and dated. At discharge, youth's placement change will also be entered. All the youth engaging in domestic violence services will have been screened by the local detention screening unit and will not meet the criteria for secure detention.

Youth's files includes service plan that reflects goals for aggression/anger management, family coping skills or other interventions designed to reduce likelihood for violence in the home.

Three Probation Respite files were reviewed; all youth were on DJJ probation, with adjudication withheld. The approval for admission was given by the Florida Network prior to the youth entering the shelter. The length of stay was found to be 14 to 30 days. Placement beyond 30 days will require the approval of the Juvenile Probation Officer, Chief Probation Officer, and the Florida Network. In the youth files reviewed it was evident that all case management and counseling needs are considered and addressed.

Only 1 staff secure youth was served during the review period. CHS will only accept youth for staff secure placement that meets the legal requirements outlined in Chapter 984.F.S. for being formally court ordered into staff secure services. Documentation of the assigned staff to the staff secure youth was noted in a variety of places, identifying youth and staff to other employees. This was documented in the log book, highlighted youth on the youth location tracking form, on the census board with youth's picture, and the assigned staff will be highlighted on the schedule in pink or red.

Domestic Minor Sex Trafficking(DMST) services are designed to serve domestic minor sex trafficking youth approved by the Florida Network who may exhibit behaviors which require additional supervision for the safety of the youth or the program. All requests may be approved for a maximum of seven (7) days. Approval for support beyond seven (7) days may be obtained on a case-by-case basis. CHS did not receive any youth meeting these criteria within the past 6 months.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The shelter had policies and procedures related to healthcare admission screening, suicide prevention, medications, medical/mental health alert process and episodic/emergency care in place. The shelter had a comprehensive master plan for access to mental health and substance abuse services, and a suicide prevention plan. The shelter provided mental health and medical services to all the youth in the center, in a homelike environment. At the admission time each youth was screened by non-healthcare staff for healthcare and mental health related conditions. The shelter makes emphasis in the participation of the youth's family in reunification and maintained the family informed and involved in the youth's performance, treatment, coordination of medical appointments, and the shelter activities. The shelter had a referral process in place, and at admission, the shelter referred to DATA any youth identified with substance abuse issues. The center offer individual, group and family counseling to parent and their children.

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 had a new 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 shelter had policy and procedures related to healthcare admission screening up-dated and approved by the program director on October 22, 2015 that was reviewed. The program's policy included all the elements required. The program's practice is to use the screening and CINS/FINS Intake form to identify any medical or mental health/substance abuse youth's condition.

A total of four youth files randomly selected were reviewed to assess the program's current practice. Of these files, three were active client files, and one was a closed file. All the four files reviewed contained a complete CINS/FINS Intake form, and mental/medical health care & follow-up notes. The intake form addressed all elements of the indicator with the exception of observation of scars, marks or tattoos that was addressed in the physical and health screening form.

Exception:

In one case the CINS/FINS Intake Assessment Form's question related to the youth's allergies was not answered, and in another case, the question related to the youth's chronic medical conditions was not answered.

4.02 Suicide Prevention

Satisfactory Limited Failed

Rating Narrative

The shelter had extensive policy and procedures for the identification and prevention of suicide risk that included screening, assessment and follow-up assessments of suicide risk, levels of supervision, and documentation.

The review of the two files applicable to suicide prevention since the last review found that the shelter uses the Evaluation of Suicide Risk Among Adolescents and completes a Client Safety Agreement on all youth admitted to the shelter. When the result of this evaluation is positive and indicated risk youth are immediately placed on suicide precautionary observation until a licensed mental health professional discontinue precautionary observation and place youth on standard supervision. The shelter's suicide risk assessment form was approved by the Florida Network of Youth and Family Services. In one additional case reviewed, the youth was Baker Act at intake before the shelter staff had the opportunity to complete the assessment.

A tour of the shelter revealed that the shelter had a Knife-for-Life available. Training documentation reviewed confirmed that the shelter staff received annual suicide prevention training. In addition, a review of the drills log found that the shelter staff regularly completed suicide prevention drills.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The shelter had policy and procedures that ensure the safe and secure storage, access, inventory disposal, administration, and distribution of medication. Observation found that the shelter stored all the prescribed medications in a Pyxis Med-Station 4000 Medication Cabinet located in the laundry room under a video surveillance system, and stored over-the counter medication in a wood locked cabinet located in the same room. Documentation reviewed revealed that the shelter maintained current inventories for all the medication in the shelter. There were no any narcotics or controlled substances in the shelter. The shelter had a list of ten staff members that received training and are authorized to administer medication. Two of the center staff received training in the Pyxis Med-Station. The shelter had a small locked refrigerator located in the kitchen pantry that was empty at the time of the review. The shelter does not have any syringes at the time of the review and had only six razors sharps. In all applicable cases the shelter had Medication Log Records (MLRs) that contained all the elements required. Observation confirmed that all the medications in the center are inaccessible to youth.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The shelter had written procedures related to the medical and mental health alert processes. Observation and documentation reviewed found that the shelter had an alert system designated to identify any medical or mental health youth issues and appropriately respond to treatment and/or emergency situation.

A review of four youth files confirmed that any alert found was documented at the admission screening in the CINS/FINS Intake form, log book, Red Alert Form, and pink mental health/medical notes. In addition, a tour of the shelter revealed that alerts were documented in a large dry erase board located in the mail room. All alerts were also found in each applicable youth's file on the Medication Log Record (MLR). Observation validated that staff check regularly at the beginning of their shift, the alert board, and the medication log to become familiar with the youth condition. There were only two youth in the shelter applicable to alerts at the time of the review and in both cases the required documentation, information and precautions were in place.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The shelter had written procedures related to episodic/emergency care that were updated and approved by the program director on October 22, 2015. Documentation reviewed found that the shelter conducted physical plant/safety inspection/housekeeping and sanitation checklists weekly, and housekeeping maintenance and sanitation tasks for staff daily. The shelter maintains in the staff office a list of all emergency numbers including rescue & fire department, law enforcement, poison control, and medical facilities.

There were ten episodic/emergency drill events documented over the last year. The shelter had two off-site emergency medical cases since the last review and in both cases the parent/guardians were notified and the daily log documentation was timely completed.

Training documentation reviewed found that all the shelter staff received training in the emergency response plan, First Aid, CPR, AED, epi-pen administration, and universal precautions. The shelter had two First Aid Kits on site, and other two that are available to the staff that transport youth in the vans. The shelter had a process in place to inform all staff verbally and in writing on a routine basis of potential emergency situations that may arise.