



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of LSF NW- Currie House

on 10/07/2015

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Limited
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Limited
1.07 Outreach Services	No rating

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care

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

Percent of indicators rated Satisfactory:71.43%
Percent of indicators rated Limited:28.57%
Percent of indicators rated Failed:0.00%

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

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

Keith Carr, Lead Reviewer, FOREFRONT/FNYFS

Kathy Parrish, Operations Review Specialist, DJJ

Elizabeth Hernandez, Reviewer, FOREFRONT/FNYFS

Gina Dozier, COO, Capital City Youth Services



Cindy Hoskins, LMHC, Clinical Supervisor, Anchorage Children's Home

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 5 Case Managers | 1 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 2 Clinical Staff | 1 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 0 Food Service Personnel | 8 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 checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input checked="" type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input checked="" type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 16 Health Records |
| <input type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 MH/SA Records |
| <input checked="" type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 13 Personnel Records |
| <input checked="" type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 11 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 17 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 checked="" type="checkbox"/> Telephone Logs | |

Surveys

- 9 Youth 6 Direct Care Staff 9 Other

Observations During Review

- | | | |
|---|--|--|
| <input checked="" 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 checked="" type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage | <input checked="" type="checkbox"/> First Aid Kit(s) |
| <input checked="" type="checkbox"/> Searches | <input type="checkbox"/> Discharge | <input checked="" 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 checked="" type="checkbox"/> Social Skill Modeling by Staff | <input checked="" type="checkbox"/> Youth Movement and Counts |
| <input checked="" type="checkbox"/> Medication Administration | <input checked="" type="checkbox"/> Staff Interactions with Youth | |

Comments

Items not marked were either not applicable or not available for review.

Rating Narrative

No cases of domestic violence respite were available for review.

Strengths and Innovative Approaches

Rating Narrative

Christmas in July was a gift for clients from the Salvation Army. Food, games, and Christmas presents made for a memorable day for everyone.

A monthly presentation (group) has been held in the shelter by a representative from the local Sickle Cell organization to educate our clients on the signs, symptoms, and care required for those who have sickle cell disease.

The agency utilizes therapy dogs on a monthly basis. The dogs visit the shelter every last Monday of the month for an opportunity for each client to interact with loving pets.

Job Corps and employment preparation presentations are delivered to residents at the program.

A weekly group on HIV/AIDS is held during the group counseling period. This group is led by two volunteers from OASIS.

The Cultural Celebrations are hosted by the agency.

Impact 100 Finalist: We have been selected as a finalist in the Impact 100 grant program this year. If chosen, the funds will be used to purchase vans.

The agency celebrated 24 year anniversary with Beth Deck, Regional Director and a 25 year anniversary with Jamie Cochran, Outreach Coordinator this year.

The agency LSF-NW non-residential program has been conducted school groups. The agency provided groups sessions in five (5) schools this past year and are already in three (3) this year. The agency counselors work with the schools to determine the particular needs of their students.

LSF conducted a YCS Staff Retreat. The Retreat was designed to afford the shelter staff an opportunity to do some fun activities while at the same time having an All Shelter Training. This has become an annual event conducted by the agency.

The agency has a partnership at a local horse ranch. The shelter clients visit the horse ranch two (2) times a month as a therapeutic outing. The agency recently attended an extra therapeutic outing – a bereavement event designed to assist with disabled children.

Standard 1: Management Accountability

Overview

Narrative

Lutheran Services Northwest (LSF-NW) is contracted by the Florida Network of Youth and Family Services to provide CINS/FINS services in the Northwest region of the Florida Panhandle. Each youth shelter operates 24 hours a day, 365 days a year and serves a range of six (6) youth up to a maximum of ten (10) CINS/FINS shelter beds in each program. At the time of this onsite Quality Improvement (QI) review, the Currie House residential program was caring for nine (9) CINS/FINS youth.

The agency promotes its broad range of service offerings to those youth and families in need through Outreach efforts in their immediate service region. The agency has several interagency agreements with local community stakeholders and partners. These local area stakeholders and partners include local schools, law enforcement, United Way, local area businesses, faith-based organizations, medical partners, homeless shelters, and various other community-based organizations.

The program has an Annual Training Plan for each staff and orientation training is provided to all new hires.

1.01 Background Screening

Satisfactory Limited Failed

Rating Narrative

All background screenings are required prior to an employee being hired to work as a mentor, volunteer, employee, or intern. All staff are required to have five year re-screenings. The Annual Affidavit of Compliance with Good Moral Character Standards is completed by the program and sent in to the Department of Juvenile Justice Background Screening unit by January 31st of each year. The program expectations are to follow the guidelines of FDJJ 1800, Background Screening Policy and Procedures. A total of thirteen staff files were reviewed from periods October 2014 through October 2015 to ensure compliance with background screenings.

The Lutheran Services Florida Northwest has a policy in place that outlines the background screening process where all staff are to have a completed background screening prior to their hire date. Five year re-screenings are done for each active employee after the date of the initial screenings. The program policy states it is the responsibility of the Senior Administrative Assistant to ensure the compliance with the Annual Affidavit of Compliance with level 2 screenings standards to be completed on a yearly basis.

All thirteen (13) staff reviewed had completed background screenings prior to their hire dates. Two of the thirteen staff were eligible for five year rescreening's. Both eligible staff had completed five year rescreening's as required. The program provided documentation of the Annual Affidavit of Compliance with Level 2 Screening Standards being completed on January 6, 2015. As a best practice all staff has a Child Care Affidavit of Good Moral Character signed in each staff file that will ensure the safety and security of the youth in their care.

The program and all 13 staff reviewed were in compliance with the FDJJ 1800, Background Screening Policy and Procedures.

None of the documents reviewed were out of compliance. No exceptions were noted.

1.02 Provision of an Abuse Free Environment

Satisfactory Limited Failed

Rating Narrative

The program provides an environment in which the youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. It is the requirement of the program to abide by the policy and procedure of the Department of Juvenile Justice and Florida Statute as it relates to reporting of abuse, suspected abuse, a child abandoned by parent, caregiver, legal guardian, or persons responsible for the child welfare. The expectations of the program are to immediately act on any allegations of child abuse appropriately according to set policy and procedures of the Department and Florida Statutes. The program must have an accessible responsive grievance process in place to address complaints of the youth.

The program has a written policy in place that adheres to the code of conduct that prohibits any physical abuse, profanity, threats, or intimidation to youth. Youth at the program are not to be deprived of basic needs such as food, clothing, shelter, medical care, and security. The program procedure outlines that all agency staff immediately reports all allegations of child abuse or suspected child abuse to the Florida Abuse Hotline at 1-800-96-Abuse, The Department of Juvenile Justice Central Communications Center. Each case is logged in a client file and is accounted in an Abuse Registry Report. Failure to report any incident of abuse could lead to serious disciplinary actions up to termination of employment. The program has a policy to address grievances during the orientation process. Grievance forms are posted in the facility to ensure that they are accessible to youth.

The program staff stated they have not had any internal abuse allegations made within the program in the last year; however, there was one incident where a staff brought her child to work and left her other children in a vehicle during her work shift. The staff supervised thirteen youth versus twelve youth and this made the ratio of supervision out of compliance. (The program was fully staffed with twelve youth.) The program provided documentation of them notifying the abuse hotline and Central Communications Center, but was not accepted and confirmed as "non-reportable". The incident is currently under investigation by the Inspector General Office. The program has an abuse registry form in each youth file where information can be documented in the event an abuse report is made. A total of nine youth surveys were completed during the review. Nine out of nine youth stated they have never been stopped or delayed in making a call to the abuse hotline. Six of the nine youth stated they knew about the abuse hotline being available for youth to report abuse at the shelter. Youth surveys revealed all nine youth stating they feel safe at the program. Six staff surveys were conducted where all six staff stated they have never observed a co-worker telling a youth that they could not call the Abuse Hotline.

The program does not have any issues of abuse incidents to report within the past year of October 2014-October 2015. The program acted accordingly to the situation with the staff as stated above to be in compliance with the abuse reports.

An exception is noted. At the time of the review during a walk-through of the program it appears to be no notification of grievances being readily accessible to youth as required. After speaking with staff, it was stated that the grievances are locked up in the intake office in a locked metal cabinet behind locked, secured doors.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

In the event an incident happens the program notifies the Department's Central Communication Center (CCC) within two (2) hours of an incident or becoming aware of an incident. The expectations is for the program to comply with the requirements of the Department and Florida Administrative Code as it relates to incident reporting.

The program has a policy in place for incident reporting. The program provides training to all staff during the first 40 hours of employment and receive additional training during the new hire orientation process, and in-service trainings. The program policy clearly states all reportable incidents involving CINS/FINS clients are verbally reported to Department of Juvenile Justice, Office of Inspector General, and Central Communication Center (CCC) within two (2) hours of knowledge of the incident. The policy outlines incidents that are labeled as reportable incidents—that includes definitions of each kind of incident.

A review of incidents from last six months (April 2015-October 2015) revealed a total of ten (10) incidents reported to the Central Communication Center (CCC).

Two of the ten incidents reviewed were reported late which was out of the required time frame of two (2) hours of gaining knowledge of the incident. Both incidents have been closed out with justifications of inconclusive for failure to report and information only due to no arrest being made by Law Enforcement.

Exceptions are noted. On one of the two late incidents the program Shelter Manager did an update on the CCC stating that there was an delay in reporting to Central Communication Center (CCC) because staff were busy making immediate contacts to 911, talking with EMS, doing a suicide evaluation on one youth, discharging youth, and supervising the remaining youth. The staff to youth ratio was met and staff called the Central Communication Center (CCC) as earliest as possible.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy approved 10/1/15 that addresses the requirements of the standard.

All direct care CINS/FINS staff are required to have a minimum of 80 hours of training during the first year of employment and direct care staff in the shelter are required to have 40 hours of training after the first year. Specific topics are outlined as either required or recommended. The policy also explains the training and/or documentation necessary for non-licensed clinical staff who work in the shelter and complete Assessments of Suicide Risk. The program has a training plan that includes offering two key components, Orientation and Workplace Safety, each month on an alternating rotation. A training calendar for the current quarter was observed posted in the staff office in the shelter. A special area of training during the past year involved participation in a shooting disaster drill for both the agency's shelters.

The Quality Services Manager maintains the training files. Each employee has a training file, which is separate from the personnel file, which contains a record of the number of hours and topics for which the employee has received training. Supporting documents such as certificates, sign in sheets or agendas are also included in many cases. This was verified by review of a total of 11 employee training files. The files the reviewer observed included a cross section of files for employees that were currently within the first year of training, as well as some who had been employed 2 years or longer. They also included staff in various categories including direct youth care workers, counselors, supervisors, the dietary specialist, residential and non-residential positions.

All of the files reviewed showed evidence meeting the minimum number of required training hours for all those who had completed at least one year of employment. Four (4) files were reviewed for staff who were still within the first year of employment. All their files reflected having had orientation and most of the required topics completed. All of the employees who had been with the program for less than a year were "on track" to obtain the required number of hours (meaning that they had a prorated average number of hours per month).

The reviewer found that there were two employee files that had New Hire Orientation Checklists that had been signed by the employee but not by a supervisor. Also, there was a lack of specific mention of Title IV-E training on the training records, though the Quality Services Manager noted that IV-E training is included as part of Orientation training. It is also on the Annual Training Plan for October and April as part of the "Reporting and Recording" training.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program has information that is recorded on a monthly basis for any corrective actions implemented, trainings, improvements made within the program to ensure that better quality of services are being rendered to youth through program improvements, according to staff and facility issues.

The program has a policy in place that collects and reviews several sources of information to identify patterns and trends data from quarterly reviews of incidents, annual reviews, monthly medication management reviews, case records, grievances, and monthly data reports.

A review of client satisfaction surveys of residential youth disclosed there were 90% of youth that stated they felt safe in the program. A review of the peer quality summary reports over a six month period revealed comments of counselors doing a great job and only two service plans missing for thirty day reviews. Special notations were made for the supervisors to follow up on these plans to ensure they are completed in a timely manner. Documentation from the NetMIS Extract on trend data indicated the numbers of year-to-date admissions was above the yearly average. Data revealed 90% of youth are living at home within 30 to 60 days and attending school within 60 days of receiving services. The program medication management practice is still

being revised to include a part-time nurse being on site to provide oversight management to medication management. In the interim, the program still utilizes their youth care specialists to assist in medication services. The program has a process in place where youth care specialists have received training by the Office of Health Services for non-licensed staff to administer medications. Quarterly Review Synopsis of incidents, accidents, and grievances from January to June 2015 shows that incident reports of medication errors were lower this quarter (January-March 2015)—no accidents and one grievance was filed by clients at the HOPE House. The employee was terminated. The Currie House is the program currently being reviewed. The status from April-June 2015 indicated medication error were down again with no grievances and no accidents to report.

There has been an identified on-going issue with the floor system that opposes a safety issue for residential youth. The program is aware of the floor system not being structurally sound for current use. The program provided documentation of them having one quote with a large estimated cost to fix. However, the program stated they could not afford to pay the amount requested to fix the floor system at this time. The program stated they attempted to get multiple quotes but was unsuccessful.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

Policy is in place that reflects the requirements of the standard. The policy indicates that the vehicle log form has a place to record the number of passengers in the vehicle (though observation of the logs reflects that this information is not recorded). Staff who was interviewed could articulate the process regarding ratios.

The agency's *Client Transportation* policy was dated 10/1/15 and approved by the Regional Director. It mirrors the language of Indicator 1.06. The policy provides guidelines regarding ratios for transportation of clients indicating that 1 staff member may transport 2-3 clients, 2 staff members may transport 4-6 clients with 1 staff member positioned between the genders, and transporting 7 or more clients requires 3 staff members. Note, that the agency has a full-size/larger capacity van that can accommodate 12 people. The policy and procedure outlines that clients may not sit in the front seat without staffing it with the shelter supervisor or the Shelter Manager. One or more staff must be seated in the passenger section of the van to supervise client behavior.

Observation of the van logs revealed that in contrast to what the policy indicates, the form does not include the number of passengers. Notations were observed in the program log book that document occasions when staff have left shelter with clients and the names of the staff and clients are included. The YCS II who was on shift at the time of observation explained that protocol is in place for special transportation situations. She gave an example of a recent situation wherein a male staff member had to transport a female client to the agency's other shelter in Crestview, FL. The YCS II (supervisor) reported that the Director was contacted when the situation arose. The staff member was approved to transport and instructed to call back to the shelter of origin upon arrival at the other shelter. The YCS II stated that the transportation situation should be documented in the program log, but she could not remember the exact date and the reviewer did not find the documentation. Following up the second day during the review, staff did not provide the documentation.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

Outreach Coordinator serves as Secretary for the Circuit DJJ Council.

Minutes from several of these meetings were presented for the past 6 months.

There were also interagency agreements with 9 other local agencies indicating good collaboration with partners. These includes entities such as law enforcement, schools, a substance abuse treatment provider, Lakeview and Catholic Charities.

The program covers Escambia and Santa Rosa Counties. Santa Rosa County has no DJJ council, but has the Northwest Florida Prevention Coalition which meets monthly and consists of partners similar to a JJ council. The Outreach Coordinator attends these meetings as well as the Escambia County Juvenile Justice meetings. Minutes of several of the Escambia County Juvenile Justice Council meetings from recent months were provided to the reviewer.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Lutheran Services Florida- Northwest delivers a wide range of services including residential and non-residential counseling services. Non-residential and residential services are provided at Currie House to eligible youth and their families across Escambia County. These services include screening, centralized intake, needs assessment, service/case plan development and oversight, as well as short-term residential care and non-residential individual and family counseling services. Specifically, LSF-NW Currie House provides a broad range of intervention and case management services to Escambia and Santa Rosa counties. These services include screening, centralized intake, assessment, service/treatment plan development and oversight, as well as short term residential (shelter) care and non-residential counseling services.

The agency currently has one Clinical Director, one Counselor III (supervisor), Counselor II and Counselor I positions to provide these services. The agency is also equipped to provide adjudication services through the Case Staffing Committee and CINS petition process for cases, as needed and appropriate, pursuant to Florida Statute 984. LSF-NW non-residential services are provided to CINS/FINS program participants and their families. The LSF-NW Currie and Hope House programs delivered intervention and case-management services through the agency's non-residential component. Services are provided twenty-four hours a day, seven days a week. The program participants receive program orientation materials upon their initial entry to the program. Program information provided to youth and parent/guardians includes confidentiality notices, release of information, service options and other orientation materials. In addition, participants are provided with information related to intake and grievance procedures.

2.01 Screening and Intake

Satisfactory Limited Failed

Rating Narrative

Eight files were reviewed: 2 open non-residential, 3 closed non-residential and 3 closed residential.

All files had an eligibility screening within 7 days of the referral. All files had a Client Informed Consent and Introduction to Services which described client responsibilities and rights and grievance procedures. This form also has a place to indicate the family was given the Guide to CINS/FINS Services for Parents brochure. This statement is not checked in shelter cases but indicated on the Prescription Consent form that the parents received a copy of this brochure.

Two of the Client Informed Consent and Introduction were not checked indicating the family was given a CINS/FINS brochure and therefore could not show if parents were told of the available CINS/FINS services.

2.02 Needs Assessment

Satisfactory Limited Failed

Rating Narrative

Eight files were reviewed: 2 open nonresidential, 3 closed nonresidential and 3 closed residential.

All files had a Needs Assessment completed with specified time-frames. Two residential files had Needs Assessment updates completed per agency policy. All files were completed by a Bachelor or Master's level staff member and included a supervisor review upon completion. No youth were identified with an elevated risk of suicide so there were no referrals for suicide risk assessments.

2.03 Case/Service Plan

Satisfactory Limited Failed

Rating Narrative

All eight files reviewed contained service/case plans that were completed within 7 working days of the Needs Assessment. Each plan was individualized and was compatible with issues identified in the Needs Assessment. The plans specified type, frequency, and location of services; person's responsible target dates and completion dates. There were signatures for all parties to the case/service plan. The non-residential case/service plans all indicated a plan initiation date.

The three residential case plans did not have a date indicating the date plan was initiated or completed. Two of the non-residential files did not show client or parent review although the client was seen regularly in sessions.

2.04 Case Management and Service Delivery

Satisfactory Limited Failed

Rating Narrative

Cases are assigned according to who completed the screening. It appeared in one case, the family was given verbal referrals for basic needs such as food and clothing. There was indication in case notes that the assigned counselors provided support and monitored the progress of families during counseling and their shelter stay.

Although it was a relatively small sample, it appeared there were few referrals for other community services. In discussion with a residential and non-residential counselor, it appeared they were not thinking of referring outside the agency for services. This was discussed with their supervisor, Jessica Mayo, as a possible training issue. There was a non-residential case reviewed that was identified as possibly needing community referrals to address a potentially aggressive youth. This was discussed with the supervisor and the assigned counselor.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

Families received counseling in accordance with case plans. The shelter program provides individual, family and group counseling. Group counseling in the shelter was not always five days a week as specified on the case plan. Of the eight files reviewed, the presenting problems of the youth were addressed in the Needs Assessment and the Case/Service Plan. Of the seven case/service plans eligible for 30 day review, assigned counselors were consistent in reviewing the plans.

Shelter groups are to be provided a minimum of five days a week. During the ten weeks (June 29th through October 2nd), there were four weeks recorded having groups five days/week, four weeks having groups four days/week and one week having groups three days/week.

Of the 30 day reviews, two non-residential files did not show the client or parent's review of the case plan, although the client was participating in counseling.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

There were no cases referred for this CINS process during the past year. The agency's policy is up to date and meet all requirements for adherence to the indicator. In addition, the agency protocols indicate the agency is prepared to activate the Adjudication/Petition Process.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

All records observed were marked confidential and kept in a locked file cabinet in a designated file room. Staff were able to access file information. Non-residential counselors have opaque and locked containers for transporting files.

Standard 3: Shelter Care

Overview

Rating Narrative

The LSF-NW has on-going contract with the Florida Network of Youth and Family Services to provide CINS/FINS services. The Currie House youth shelter serves multiple residential group care populations including Dependency, Staff Secure, DJJ Domestic Violence and DJJ Probation Respite. This contract serves youth that are considered status offenders. These services include entry level of intervention and treatment for youth and families that are at risk for legal complications such as chronic runaway, lockout from the home or repeated school truancy.

The overall shelter environment is orderly, clean and staff seem positive. The agency has an established program orientation for all new residents admitted to the program that is provided during the intake process. The program orientation includes all the required elements outlined in CINS/FINS Standard 3 and is documented in the client files. Room assignments are completed by the Youth Care Staff at time of intake and are thoroughly reviewed, ensuring that any youth placed in a room with another resident is not a threat to the safety of him/herself, another resident, and the staff in the program. The agency has a very well established behavior management system that consistently implements to influence the youth to make positive choices and increase his/her personal accountability and social responsibility.

The program provides programming to engage youth in a variety of healthy activities. Staff ensure the program is clean, well maintained, safe and secure. Schedules and activities are posted for staff and youth to access. Youth are engaged in education, recreation, counseling services, life and social skills training.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

Shelter Environment-

Disaster Plan. Agency has an updated disaster plan that is revised annually as per policy and procedure. Plan is detailed and includes various disaster and emergency situations. Plan includes all components of FNYFS policy and procedures. Program has submitted the Disaster Plan to the Florida Network as required. Program included a "shooting" disaster drill over the past 6 months. Facility provided summary of the drill to include critique and corrective action.

Health and Fire safety inspections are current as of June 18, 2015. Program has fire extinguishers mounted throughout the program that have current inspection dates. Program demonstrated being proactive in correcting concern noted on June 16, 2015. Annual facility fire inspection is conducted as is required by standard. As of this review the facility is in compliance with local fire marshal and fire safety code within the appropriate jurisdiction.

Fire Drills. Program has documented a minimum of 1 fire drill per month with the recorded completion waiting 2 minutes or less.

Mock Emergency Drill- one (1) drill was presented at the time of review. Drill met all requirements, documented and dated.

Knife for Life. Facility is equipped with Knife for life. Staff are aware of the location and need for use. First aid kits are available as are bio-hazard waste and disposal bin(s).

Bio-Hazard waste disposal bins-located in the Youth Care Specialist office. Staff are aware of the location and the need for use.

Agency and staff vehicles are locked and secured. Agency vehicles are equipped with first aid kits. Staff was able to verbalize the protocol for using/replenishing first aid kits. Glass breaker, seat belt cutter are all observed present in the van. Insurance is current/up-to-date for the vehicle. Staff reported that they do not transport youth/clients in their personal vehicles.

Department of Health. Facility has current Department of Health Operating Permit/Group Care-Child Caring Agency. Permit expires on September 30, 2016. Agency has Food Service Inspection report posted from the Department of Health (dated 11.21.14). Food menus posted are current and are signed by the Licensed Dietician annually. All cold food is properly stored, marked and labeled. Dry storage/pantry area are very organized and clean. Food is properly stored. Refrigerators/freezers are very clean and organized. Observed working thermometers maintained at required temperatures. Appliances are all clean and in working condition.

***10.08.2015--Department of Health Inspection completed with a satisfactory rating.

Facility and Site Inspection

Agency has a current DCF Child Care License with expiration date of September 27, 2016. License was displayed openly at the facility.

Exterior area are free of debris--grounds are free of hazards and well-maintained. Observed exterior lighting in good working condition. Dumpsters and garbage can(s) are covered. All doors were secured and required key for in and out access. Access to secured areas is limited to staff members.

Agency has invested into major maintenance/physical plant updates/upgrades over the past 6 months. Investments have included air conditioning and water heater.

Facility has a key control practice that requires staff to document in the log book when they receive keys as well as what set of color coded keys they are in possession of during their shift. Documentation observed in the log book entry.

Observed the facility detailed map and egress plans posted throughout the building and near exits. Program also had general client rules, Abuse Hotline information and DJJ Incident Reporting number visibly posted in common areas for all youth to see and have access to.

Grievance Policy. Program has a formalized grievance process in accordance with standard/policy and procedure as is required. Youth are informed of their right to file a grievance during their intake process. Policy provided by the program indicates that grievance forms are accessible to youth. Youth are provided with the steps/phases they may follow when filing a grievance. A youth was able to verbalize having knowledge of the grievance process. Program reports indicate that there were no grievances reported during the period of January 2015 through the present date October 7, 2015. Protocol does indicate that the facility will work to resolve grievances within a 72-hour time-frame.

All interior lighting is operational and interior areas are clean with no insect infestation observed at the time of this walk-through. Furniture appeared to be in clean and working condition. No graffiti was observed throughout the facility.

Youth bedrooms provided beds for each youth. Bedding: sheets, spreads and pillows provided all appear to be in good, clean condition. Client Room Assignment/classification is addressed during the intake assessment process. Rooms are numbered and staff verbalized protocol for identifying bed assignment. Facility takes into consideration age, gender, history of criminal offenses, behavior (aggressive/nonaggressive), attitude, mental health concerns.

No contraband was observed in bedrooms, bathrooms, common areas. Overall, all areas appeared to be very clean and neatly organized with no safety concerns noted. Cameras were operational and provided clear line of sight to the areas being monitored.

Chemical Inventory. Electronic list of chemicals used by the facility for the month of September 2015 was present. List included beginning and ending inventory for specific chemicals. Inventory provided was the monthly inventory for September 2015.

MSDS Log. Facility maintains an MSDS log that contains information sheet for all chemicals used in the program.

Washer and dryer are operational. Laundry room facilities are in clean/organized condition.

Shelter has an organized weekday, weekend and holiday schedule. Shelter also has a summer schedule. All schedules are posted for staff and youth to view. Schedules are also provided to each youth during the intake process. Schedules are provided to youth in their client handbook.

Shelter provides youth with cultural awareness/diversity and celebrates on a monthly basis different backgrounds and ethnic groups.

Disaster Plan. Agency provided a written report of Disaster Drill. Documentation was missing signatures for participants and verification of date of completion.

Health and Fire safety inspection. Primary Violation noted for the agency by fire marshal on June 16, 2015. Report provided. Agency complied with making necessary corrections. Passing inspection with no violations was on June 18, 2015.

Fire Drills. Program documented a total of (3) fire drills for the month of September 2015. Fire Drill documented for September 15, 2015/2nd Shift noted that fire drill was under the 2 minutes. However, staff noted that youth was in the shower. Did youth remain in shower during the fire drill? Fire drill documented on September 30, 2015 duration was over the 2 minutes. Staff noted that one youth refused to participate.

Kitchen. Very organized and clean. All postings are visible, clean and easy to read. Kitchen staff very familiar with the required postings and was helpful with providing information as requested. Department of Health inspection report posted dated for 11.21.2014.

***10.08.2015--Department of Health Inspection completed with a satisfactory rating.

Grievance Process. Grievance forms should be posted in the facility to ensure they are accessible to the youth. Grievance forms were not posted and therefore not easily accessible to the youth as or when needed. Youth would be required to request a form from staff and no observation of youth having access to turn a grievance in other than placing it in the hands of staff. No grievance box that provides clear, accessible, and fair avenues for lodging complaints.

Walk-through observations. All common areas appear to be very clean and organized. Sufficient seating for all youth at the facility. Youth bedrooms very neat/organized and clean.

Flooring in the common area has some visible cracks and concerns with the tiles/flooring. Cracks in the tile and in some areas are raised and pose a safety concern. Concerns with this area of the flooring was noted during prior review. Agency is aware and acknowledged the need for the repair. Agency provided (1) bid for the repair of the floor. No other documentation was provided at this time to demonstrate an ongoing effort to have the floor repaired and reduce a potential risk factor.

Bedrooms are numbered for identification purposes. Beds are referred to as "right" / "left". Not labeled at the time observation.

Mock Emergency Drill. Drills are required to be completed at the frequency of 1 mock emergency drill per shift per quarter. At time of review, the agency did not provide documentation of mock emergency drills completed in the past quarter.

Chemical Inventory. No log/documentation of chemical inventory being completed at a minimum of 1 time per week by the agency. List provided did not specify what date inventory was completed, frequency of completion, who chemical was issued to or when, if returned. Staff signature/initials needed for accountability purposes.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

In reviewing Indicator 3.02-Program Orientation, 4 closed files were reviewed. KM, JA, SB, and WB. All (4) closed files contained required documentation with regards to the youth's program orientation. All youth received orientation within the first 24 hours of intake and by practice the program ensures that youth receive orientation process immediately following youth's intake. Staff completes program orientation with the youth during which they discuss the program's philosophy, goals, services and expectations. Three (KM, SB, WE) out of four (4) closed files contained the required signatures (youth, staff, parent/guardian) on all forms. One (1) file, JA, was missing parent/guardian signature. Documentation of detailed orientation, including all topics reviewed with the youth, parent/guardian and staff plus dates reviewed were found in all four (4) closed files.

In reviewing Indicator 3.02-Program Orientation, 3 open files were reviewed (AA, TW, LW). All open files contained required documentation with regards to the youth's program orientation. All youth received orientation within the first 24 hours of intake and by practice the program ensures that youth receive orientation process immediately following youth's intake. Staff completes program orientation with the youth during which they discuss the program's philosophy, goals, services and expectations. One (1) open file, AA, was missing parent signature on the Client

Safety Agreement form. Documentation of detailed orientation, including all topics reviewed with the youth, parent/guardian and staff plus dates reviewed were found in all three (AA, TW, LW) open files.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

In reviewing Indicator 3.03-Youth Room Assignments, 4 closed files were reviewed. KM, JA, SB, and WB and 3 open files were reviewed (AA, TW, LW). All files reviewed contained information used through a classification process that ensures the most appropriate sleeping room assignments. The classification process used by the facility to select the best possible room assignment and identify potential safety and security concerns includes information about the youths' history. History includes but is not limited to status and exposure to trauma. The program considers age, gender, height, weight as well as criminal offenses/delinquency, gang affiliation, sexual assault or misconduct. Other areas are discussed/reviewed during the classification process prior to final room assignment. Areas taken into consideration are discussed and documented in the youth individual files.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

Log Books were observed at the time of this review. Observation/review of log book entries demonstrated that staff use the log book to communicate from shift to shift. Staff documents and highlights required information to include population, med call, transports, youth interaction, phone calls and other significant movements within the program.

Staff documents bed checks in the log book for overnight counts. Review of log book indicates that staff completes bed checks within 10 minute intervals as is required. Staff documents when they read the log book as well as the exchange of keys. Late entries are highlighted. Most entries are legibly written with staff initials at the end of each entry. Review of log book by staff is consistently noted throughout the log book from shift to shift. Supervision and resident counts are documented. Movement/transports are all documented with exit and return times. All entries in the log book are completed in ink without any erasures. No use of white out in the log book.

Log books are permanently bound with sequential pages as is required.

Strike through/void of entry should be initialed. Staff should only strike through any errors with one line.

Staff used back sheet in the log book. All entries are to be made on the lined-numbered pages.

Review of log book indicates no reference for the different color highlights. (Legend recommended for review purposes.)

Supervisor review of log book not observed consistently.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

Behavior Management Strategies are in place in order to positively motivate youth to gain compliance with program rules. BMS is presented to the youth as a tool/guide to make positive choices and increase personal accountability and social responsibility. Youth are presented with a detailed written description of the BMS in the client handbook provided to them during the program orientation. Staff informs youth the process of earning positive/negative points. Included in the description, youth are informed how they have the opportunity to earn back up to half the points they lost. Youth are aware that they can earn back points by staying calm and practicing any of the steps they missed that resulted in the loss of points. BMS includes a point card and is clear as to the consequences and sanctions used by the program. BMS is designed to provide constructive discipline free from harm while encouraging the youth to follow the rules and expectations. It promotes an improved quality of life for youth which conveys they are able to seek positive outcomes of good decision-making.

Reviewer observed BMS point store that youth can use earned points to purchase selected items.

All staff are consistently trained in the theory and practice of administering the BMS rewards and consequences. Supervisors are trained to monitor the use of rewards and consequences. Training of the BMS was noted in the individual staff training files. Staff are able to verbalize the practice and benefits of using the BMS consistently with every youth.

BMS provides youth with the opportunity to earn additional privileges including watching TV, phone time, free time, special snacks and other surprises as provided by the program.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy in place that meets general ratio requirements. Program maintains a staffing pattern of one staff to 6 youth during awake hours and community activities. The overnight ratio for the program is one staff to every 12 youth during the sleep period. Program reports one (1) part-time Youth Care Specialist vacancy and one (1) Youth Care Specialist II.

Program staffing pattern has not supported requirement to maintain at least one staff on duty of the same gender as the youth on each work shift including all overnight work shifts. Overnight shifts consistently maintain a minimum of two (2) staff, however, on most nights both staff are of the same gender. Staff schedule shows that there has not been a male/female compliment for all three shifts.

Agency policy calls for a holdover or overtime rotation (3.06-#4). Program does not have any formalized process, but does expect that if Youth Care Specialist cannot report to work that they assist with finding coverage for their assigned shift.

Review of logbook supported policy requiring staff to complete 10-minute checks while youth are sleeping—either during the sleep period or at other times, such as during illness or room restriction.

Cameras were observed throughout the program. Cameras were all in working condition at the time of walk-through. Cameras provided clear sight of the areas being monitored.

Program provide written documentation to support their efforts/challenges with recruiting qualified male staff. Agency has advertised through several avenues to include Employ Florida, Monster.com and simple word of mouth. During this review program reported that they had one male staff resign. Program has scheduled on staff two (2) full time YCS-II positions and the positions are filled by female staff. Four (4) full time positions on the schedule are all filled by female staff. Four (4) part-time positions are currently filled by 2 male and 2 female employees. Agency also has on the staff schedule 4 temporary positions all currently filled by female staff.

Exceptions are noted for this indicator.

Program does not currently meet the male and female guidelines.

Program has not been able to staff consistently to accommodate policy requirement of maintaining one staff on duty of the same gender as the youth on each work shift including overnight work shifts.

There is no current formalized process for holdover or overtime rotation roster. Policy 3.06 (#4). Staff reported that the informal practice when the need arises is the responsibility of the YCS or supervisor/on-call.

Credible proof of effort to meet the requirement is not clearly documented as of this review.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The program has Staff Secure policies and procedures in place. The agency has not had any staff secure cases/placement in the last 6 months or since the last onsite QI review was conducted.

Program does have a policy outlining the requirements/expectations for a staff secure placement that includes orientation and admission, assessment and service planning, enhanced supervision, parental involvement and collaborative aftercare.

Program has not had any Staff Secure placements. Therefore, reviewer is unable to observe practice of policy with regards to bed assignments and assigned staff supervision to one staff secure youth at any given time. Staff was able to identify that a policy is in place and was able to discuss steps/requirements needed if a Staff Secure placement was necessary.

Program does have applicable Domestic Violence Respite policies and procedures in place. At the time of this review the program has one youth (AA) currently in the shelter as a DV placement.

AA has a pending Domestic Violence charge. AA was referred to the program by DJJ. AA has been in the shelter since September 28, 2015. His length of stay is not to exceed 14 days as a DV respite client.

Case Plan reflects goals for reunification with the family—effective communication skills and techniques to manage anger.

Agency has policy and procedures for Probation Respite but reports that they have not had any youth placed under this criteria. No noted Probation Respite in the last 6 months or since the previous QI review was conducted. Staff is aware that a policy does exist and shared that they would review policy in order to ensure that all areas were in compliance if a Probation Respite placement was needed at the facility.

Agency has Domestic Minor Sex Trafficking policy and procedures. At the time of this review and since the previous QI review there has not been any Sex Trafficking youth admitted to the program. Staff is aware that a policy does exist and shared that they would review policy in order to ensure that all areas were in compliance if a Domestic Minor Sex Trafficking placement was needed at the facility.

AA--Case plan was typed, easy to read/follow. Goals were clear and interventions were measureable. Plan is up to date at this time.



Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The LSF-NW Currie House program has comprehensive policies that address program requirements related to health admission screening, behavior management, mental health and suicide risk assessments, medication distribution, general alert systems and medical and mental health alert. A review of the agency's protocol regarding the shelter environment was conducted and contains policy and language that meets the general requirements of this indicator. The agency's current suicide assessment practices and policies have been reviewed and approved by the Florida Network of Youth and Family Services. To execute these services, the agency utilizes master's level counselors, a Residential Supervisor, a Shelter Services Manager and a Licensed Mental Health Clinician. The Shelter Services Manager oversees the agency's residential services and the Licensed Mental Health Counselor oversees all counseling and assessment services on a daily basis.

4.01 Healthcare Admission Screening

Satisfactory Limited Failed

Rating Narrative

The agency has four (4) CINS/FINS shelter sites. The policy in use at this site is the same across all 4 LSF shelters. The agency has a detailed policy on Healthcare Admission Screening and the agency's practice in this area. A review of the agency's current policy was conducted on-site and the current policy was found to have met general requirements for the agency's staff to conduct healthcare screenings on 100% of all clients admitted to their programs. This health screening process is initiated during the healthcare screening process and also during the intake/admission process. The current screening form does screen recently admitted clients if they have any existing or past health issues. The agency completes further screening through the use of the CINS Intake Assessment Form. The CINS/FINS Intake Form screens each youth for a broad range of health and medical conditions. The agency's health screening form addresses all elements of the indicator. The screening form asks about the past, recent or current status of medications, existing medical conditions, allergies, recent injuries or illnesses, presence of pain or other physical distress, observations for evidence of illness, injury, physical distress, difficulty moving, etc. and observation for presence of scars, tattoos, or other skin markings.

The LSF policy does specifically lists examples of major medical conditions to include diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries which occurred during the previous two (2) weeks, acute allergies, chronic bronchitis or other chronic disorders

A review of nine (9) open residential client files reviewed contained documentation of the CINS/FINS Intake form that was completed by direct care residential and screening staff. The agency documents health screening findings from this form that documents all elements of the indicator. The agency has a separate form that documents the observation of scars, marks or tattoos. All 9 files reviewed contained the required forms. The written practice addresses the referral process and follow-up medical care.

4.02 Suicide Prevention

Satisfactory Limited Failed

Rating Narrative

The agency has four (4) CINS/FINS shelter sites. The policy in use at this site is the same across all 4 LSF shelters. The agency has a detailed up-to-date policy and procedures for the Suicide Prevention screening, assessment and supervision practice. A review of the agency's current policy was conducted on-site and the current policy was found to have met general requirements. The agency's policy requires that all residents and non-residential clients admitted to one of the programs be screened for suicide risks. The current practice for screening for suicide requires that the agency use the CINS/FINS intake form and the Evaluation of Imminent Danger Survey (EIDS) to determine the past and present risk for suicide. The agency uses the CINS intake form at Intake. The CINS intake form screens each program participant for suicidal risk by asking each the six (6) suicide risk questions. The EIDS is also used during intake and a resident that meets a score of 5 or more is placed on suicide risk observation status. The agency has two (2) levels of suicide risk supervision that include Sight and Sound and Elevated Supervision. At the time of this review, the agency's current plan for addressing suicide risks addresses all general elements of the indicator and complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.

A total of five (5) files residential client files reviewed on-site contained evidence that each was screened for suicidal risk by the using the six (6) suicide risk questions on the CINS/FINS intake form. Each of these 5 files also had documentation that an EIDS was executed on each admission. The EIDS rating warranted each resident be placed on suicide risk observation. The documentation of each resident resulted in a positive rating for the presence of suicide risk. In all 5 case files reviewed the program immediately contacted the Residential Counselor or Licensed Clinician to verify the placement of the youth on sight and sound status. Each client file reviewed in this sample had documentation of observation-check logs and official assessments completed by non-licensed staff being overseen by a licensed clinician on staff. A review of observation logs indicate that observation checks are being documented. Documentation of clients being placed on sight and sound status; bed checks conducted on the overnight shift; and taking youth off sight and sound status are documented as required in 3 out of 5 clients files reviewed.

At time of this review, the agency has 2 residential counselors that have been employed with the agency for less than four (4) months. Each counselor has documentation verifying they are working towards the completion of a minimum of 5 assessments. This is verified by documentation of the Non-Licensed Mental Health Clinical Staff Person's Training in completing Assessment of Suicide Risk. Supportive documentation was reviewed to include precautionary observation logs and thirty minute checks.

Exceptions were noted. Two (2) out of five (5) clients being placed on sight and sound status revealed findings. In these cases bed checks conducted on the overnight shift and taking youth off sight and sound status were not consistently documented as required in the aforementioned areas. Documentation of findings include missed documentation times.

Youth on sight and sound status were taken off Sight Sound status per the consultation with LMHC. However, removal status of youth was not communicated to residential staff in real-time.

One out of five (5) files is missing a signature verifying consultation with the licensed clinician.

4.03 Medications

Satisfactory Limited Failed

Rating Narrative

The program has a current list of staff that are trained and designated to have access to secured medications and limited access to controlled substances.

All medications in the shelter are stored in a separate youth care worker office next to the Youth Care Workstation. This office is locked and not accessible to residents in the youth shelter. All medication is housed in the CareFusion MedStation Pyxis 4000 automated medication cart. Each medication is stored separately in an individual MedStation storage cube. The MedStation holds a specific number of individual cubes on 6 individual rows. At the time of this on-site program review, the agency does not have a Nurse employed to oversee part-time medication duties. The agency reported that they are in the process of hiring a Registered Nurse. All topical and oral medications are stored in separate storage cubes or holding bins. There were no injectable medications on-site or identified as needed for any youth during the time of the review. The shelter has a refrigerator specifically for medication. At the time of this on site review, there were no medications that required refrigeration. Controlled medications are locked in the MedStation behind stage 1-password access and 2-bio-metric finger print access. Shift-to-shift counts and a perpetual inventory are maintained, and documented for controlled and prescribed medications. Sharps are maintained in a locked cabinet. Scissors are maintained in the Residential Supervisor's office. The agency's Medication Distribution Log (MDL) contained all the necessary information to include: youth's name (printed and signed), date of birth, allergies, side effects, picture of youth, staff and youth initials when medication is distributed and received. Shift-to-shift counts for controlled medications occur at each shift change and on a perpetual basis. Over-the-counter medications that are accessed regularly are inventoried weekly on a perpetual inventory. The shelter generally maintained a daily count of the sharps on a weekly basis for the last six (6) months.

A review of a mix of open and closed client residential files on medication was conducted. A review of these files indicated that there is general compliance with the medication distribution requirements. All client files included the required MDL, consent and medication information as required.

There are exceptions noted for this indicator.

There are a total of 2 medication errors reported to the DJJ CCC. The reports indicate that the same staff was identified as being involved in a complaint against staff incident. This staff is documented as not having received re-training and was not documented as being present at the agency's most recent meeting of the Medication Management-Non-Licensed staff with Epi-Pen Training delivered by the Office of Health Services on September 24, 2015.

Funds for the acquisition of a Registered Nurse were made available at the start of the fiscal year July 2015. The agency states that they will be in the process of finalizing the hiring of a Nurse for the residential youth shelter before the end of the calendar year.

Medication distribution logs for client counts indicate the presence of periodic blank spaces for resident signature and/or staff documentation verifying the distribution of medication. Documentation of previous shift is documented over the current shift but staff did not use the notes or comments section to explain error and adjustments required to correct the preceding error.

4.04 Medical/Mental Health Alert Process

Satisfactory Limited Failed

Rating Narrative

There is a policy in place that outlines an alert process that is congruent with the requirements of this indicator. The process includes medications, allergies, and mental health issues being noted on the pass-down log and colored coded stickers being placed on the client files. A total of 7 open client files were reviewed.

The forms in one youth's file indicated that the youth was on methylphenidate ER and had a mental health history of depression and affirmative responses on the risk questions that prompted sight and sound observation until being assessed and removed on 9/20/15. This youth's file did not have an alert dot on it.

There were additional exceptions noted. Errors on 3 files indicated almost 50% were incorrectly alerted. Considering that some youth did not require any special alert, the percentage needing alert that were incorrectly done was even higher.

Another youth had an allergy to a particular soap noted on his Health Screening form. The "medical alert designated on file" was circled "no". There was a red dot on his file labeled "DV against mom". Indeed, the youth did have a domestic violence charge. According to the agency's policy and procedure, a red dot indicates several high risk issues, including a history of assault or aggressive behavior. However, the policy also specifies that green dots are placed on files for medication or medical conditions and blue dots specifically are placed on files if client is in shelter for Domestic Violence Respite.

A third client was admitted on 9/24/15 was on one medication. There was no dot on the file until 10/8/15 when the reviewers brought it to the staff's attention. This youth is also reported on the pass-down log to have an allergy to AXE Soap. This allergy should have been noted on this youth's pass-down log.

4.05 Episodic/Emergency Care

Satisfactory Limited Failed

Rating Narrative

The agency has four (4) CINS/FINS shelter sites. The policy in use at this site is the same across all 4 LSF shelters. The shelter has a written policy that addresses the requirements of the indicator for the Episodic/Emergency Care. The policy was last reviewed on October 1, 2015. There were five (5) emergency events within the last six (6) months. All episodic events were documented in the Incident and Actions binder or in the DJJ CCC Log. There was documentation for the parent/guardian notification requirement and obtaining off-site emergency services (i.e. EMS or the police for Baker Acts). The agency does provide a series of emergency training topics that include CPR/First Aid, Crisis Intervention, Disaster Planning, Fire Safety, Program Safety, HIV/Health Related Issues. At the time of this review, the shelter had a first aid kit, wire cutters and a knife-for-life.

Exceptions are noted. A review of eleven (11) staff member training files indicated one (1) on-going staff person was missing documentation for current CPR and First Aid certification. At the time of this on site program review, the agency only provided evidence of conducting one documented emergency drill in the last six (6) months.