



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of LSF SE- Lippman

on 03/06/2013

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 Interagency Agreements and Outreach	Satisfactory
1.06 Disaster Planning	Satisfactory
1.07 Analyzing and Reporting Information	Satisfactory

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Psychosocial 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 Youth Room Assignment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Shelter Environment	Limited
3.04 Log Books	Satisfactory
3.05 Daily Programming	Satisfactory
3.06 Behavior Management Strategies	Satisfactory
3.07 Behavior Interventions	Satisfactory
3.08 Staffing and Youth Supervision	Satisfactory
3.09 Staff Secure Shelter	Satisfactory

Percent of indicators rated Satisfactory:88.89%
 Percent of indicators rated Limited:11.11%
 Percent of indicators rated Failed:0.00%

Standard 4: Mental Health/Health Services

4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Limited
4.03 Medications	Satisfactory
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:92.86%
 Percent of indicators rated Limited:7.14%
 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 and Consultant, Forefront LLC

Marie Boswell, Delinquency Prevention Specialist, Department of Juvenile Justice

Nitara Wiggins, Quality Management Specialist, Children's Home Society Treasure Coast



Quality Improvement Review

LSF SE- Lippman - 03/06/2013

Lead Reviewer:

Tom Popadak, Training Coordinator, Florida Network of Youth and Family Services

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 0 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 4 Clinical Staff | 3 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 0 Food Service Personnel | 4 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 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 checked="" type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 12 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input 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 | 8 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | 1 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

- | | | |
|-------|-------------------|-------|
| Youth | Direct Care Staff | Other |
|-------|-------------------|-------|

Observations During Review

- | | | |
|--|---|---|
| <input type="checkbox"/> Admissions | <input type="checkbox"/> Posting of Abuse Hotline | <input type="checkbox"/> Staff Supervision of Youth |
| <input type="checkbox"/> Confinement | <input type="checkbox"/> Program Activities | <input type="checkbox"/> Tool Inventory and Storage |
| <input type="checkbox"/> Facility and Grounds | <input type="checkbox"/> Recreation | <input type="checkbox"/> Toxic Item Inventory and Storage |
| <input type="checkbox"/> First Aid Kit(s) | <input type="checkbox"/> Searches | <input type="checkbox"/> Transition/Exit Conferences |
| <input type="checkbox"/> Group | <input type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings |
| <input type="checkbox"/> Meals | <input checked="" type="checkbox"/> Sick Call | <input type="checkbox"/> Use of Mechanical Restraints |
| <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 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 Lutheran Services Florida (LSF) Broward is a Children In Need of Services/Families In Need of Services (CINS/FINS) program that provides residential and non-residential services to youth in Broward County. The program is sub-contracted through the Florida Network of Youth and Family Services (Florida Network). The program operates the Lippman Youth Shelter, located in the City of Oakland Park, Florida. The shelter provides twenty-four hours, seven days per week, crisis emergency services for youth ages ten to seventeen years of age that do not have any current open cases of delinquency or dependency in Broward County. The Non-Residential program known as Broward Family Center is located in the same offices as the agency's Administrative Offices at 4185 North State Road 7 in Lauderdale Lakes. The program has been at this location since December 2011 and the offices are located on the second floor of the Lakes Medical Center Building, just two blocks south of the old location at 4675 North State Road 7.

Lutheran Services Florida Inc. was accredited by the Council on Accreditation (COA) in 2005 and has been continuously re-accredited by COA since its accreditation. Its current COA accreditation is effective through 2/28/14. This consistent achievement demonstrates the organization's commitment to maintaining the highest level of standards and provision of quality services to its consumers.

LSF Broward is a current member of the national Safe Place Program, a network of voluntary community sites where youth in need of help can go for safe refuge. Although there isn't specific funding for this Outreach Program, the provider has continued to partner with local businesses and schools to help youth in trouble. A designated staff is responsible for Safe Place site recruitment, training, and ongoing support as well as community and school presentations. The efforts of the program are evident by the display of the Safe Place sign on county libraries, fire stations, and other prominent businesses which make up a total of 106 Safe Place Sites in Broward County.

The program has traditionally served the needs of at risk youth ages 10-17 years and is well aware of the needs of youth transitioning into adulthood. Through its partnership with Broward County "Second Chance" Program, LSF Broward is now also able to provide case management services to transitional youth ages 17-21 years. The Second Chance program provides housing-focused case management and one year of housing and utility subsidy for these older youth, enabling them to learn how to budget, to save money, to locate and utilize community resources, and to put into practice the real-world life skills they are learning.

Standard 1: Management Accountability

Overview

Narrative

LSF Broward operates both the Lippman Youth Shelter (residential) and Broward Family Center (non-residential) CINS/FINS Program in Broward County. The program has a management team that is comprised of an Associate Vice President of Quality Management; an Executive Program Director; a Residential Manager, a Clinical Supervisor (Counselor III) who is both a Licensed Marriage and Family Therapist (LMFT) and PhD, and a Senior Administrative Assistant. At the time of the review, the program had a full compliment of staff but has experienced significant turnover since the last onsite review in May 2012, and has hired ten new staff including that of the Shelter Manager position which was vacant for two months. The Executive Program Director oversees the activities of both the residential and the non-residential programs. The shelter program staff structure includes: a Program Manager, a Dietary Specialist, a Counselor II, a YCSIII supervisor, three YCS Team Leaders, and five fulltime, and nine temporary YCSI. In addition to the Clinical Supervisor, the non-residential component has four Counselor positions, one shared as an Outreach Specialist, and a Lead Program Assistant.

The program has an Annual Training Plan for all staff and orientation training is provided to all new hires. Employees receive ongoing training from the program's local providers and the Florida Network. Each employee has a separate training file that contains a training plan and supporting documentation for training received. Annual training is tracked according to the employee's date of hire.

LSF Broward maintains valuable interagency agreements with thirty-seven agencies that ensure a continuum of services for the youth and families. The program has an Outreach Targeting Plan and a strong outreach component with participation of all program staff and emphasis on the designated high crime zip coded areas as well as low performing schools.

The Florida Network acknowledged receipt of the program's Disaster Preparedness plan for FY 2012-2013 on February 20, 2013; the current plan is dated January 31, 2013 and the Fire Safety Plan was approved by the Fire Rescue Department on February 4, 2011. The Department of Children and Families has licensed Lippman Youth Shelter as a Child Caring Agency, with the current license in effect until June 27, 2013.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedures that address the background screening of all Department of Juvenile Justice employees, contracted providers, and volunteers as well as anyone else with direct and unsupervised access to youth. The screening is required to be conducted prior to hiring an employee or volunteer and is conducted using Live Scan. In addition to the DJJ Background Screening, the provider also conducts driver's license screening at hire and quarterly thereafter, annual local municipality and county screenings, and a drug screening upon hire as well as randomly thereafter. Proof of the fax submission of the Annual Affidavit of Compliance with Good Moral Character Standards, sent to DJJ on January 14, 2013 prior to the January 31st deadline, was provided.

A total of twelve (12) personnel files were reviewed for ten (10) new hires and two (2) volunteers. All of the ten new hires were screened and received an eligible screening result prior to their hire dates. Similarly, the two volunteers utilized by the provider during the review period were background screened and eligible screening results were obtained prior to providing volunteer services.

The program reported one staff arrest that occurred concurrently with an abuse allegation by youth against said staff. The staff was immediately terminated and the incident was reported to CCC.

The provider did not have any eligible five-year re-screenings for the review period.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedures in place that address all elements of the indicator and include procedures for: 1) enforcing a code of conduct regarding staff's behavioral expectations, 2) mandating the reporting of all allegations/suspected abuse to the abuse hotline, and 3) requiring management to take immediate actions to address incidents of physical and/or psychological abuse or staff's failure to adhere to the agency's behavioral policy.

Upon hire, staff receives a copy of the agency's Personnel Policies and Procedures that includes a description of its behavioral expectations and code of conduct in Section 12 of the manual. An acknowledgement of receipt is signed by the employee and a copy is maintained in the employee's personnel file. The program also has a detailed policy and procedures regarding the Provision of an Abuse Free Environment Child

Abuse Reporting. Staff's responsibility and protocols for reporting child abuse are clearly outlined in the procedures. Corporal punishment is prohibited and shelter staff is required to sign a Corporal Punishment Acknowledgement statement indicating receipt and knowledge of the policy.

Per the Program Director, there was one incident in August 2012 where a youth alleged maltreatment by staff which resulted in small bruises to the youth. The allegations were found to be true and the staff was terminated.

The Abuse Hotline telephone number is visibly posted on two doors in the counseling hallway and on a board in the youth's lounge. The abuse hotline phone number is listed in the Resident Handbook that is reviewed with youth and parents during admission. Also included in the handbook are the youth's rights, information on the grievance process, and behavioral expectations. The youth and parent/guardian sign the orientation checklist acknowledging receipt of the handbook and their understanding of the information provided during orientation. This form was located in all files that were reviewed.

According to the program manager, there was only one youth grievance in the past six months. The youth complained about one staff's assumption that she was involved in an altercation. Staff stated that the grievance was not resolved because the youth submitted it upon discharge on February 3, 2013.

The three youth surveyed stated that they knew about the abuse hotline but one of the youth was unaware of the location of the telephone number. All of the youth surveyed indicated that they feel safe in the shelter and feel that the adults are respectful when talking to youth. None of the youth reported hearing staff threaten them or other youth.

The three staff surveyed said they have never witnessed another staff prohibit youth from calling the abuse hotline and have never heard observed staff using threat, intimidation, humiliation, or profanity when interacting with youth.

A log is maintained for all calls made to the Abuse Hotline. However, copies of the six abuse reports made in the past six months were not placed in the provider's binder that only had reports between 2009 and 2010. Also, records of the abuse hotline calls were not being documented in the logbook as required by the provider's policy.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedures in place that address all elements of the indicator.

A total of 20 incidents were reviewed for the review period. All reportable incidents clearly describe the incident and were reported within the appropriate timeframe. However, in review of the program's log book, CCC Incident Report Log, and the Incident Reports, there were inconsistencies in the documentation of the incidents. The DJJ/CCC section of the Incident Report forms were not completed on any of the Incident Reports reviewed. This would have provided the CCC Incident number, reporting dates/times, and advised if the incident was accepted/rejected.

It is recommended that the DJJ/CCC section of the agency Incident Report form be completed in full. It is noted that this issue was addressed in a staff meeting on 11/28/12 and again addressed in a staff meeting on 2/20/13.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedures in place that address all elements of the indicator.

A total of six (6) training files were reviewed for three (3) first year staff and three (3) in-service staff employed more than one year. A review of the files documented that, during the first year of employment, direct care staff received in excess of the required 80 hours and the sessions included the required trainings.

The files reviewed of the staff employed for more than a year document that staff is working toward completion of the required 40 hours of required annual training. However, one staff (DOH 3/17/11) who received 30.3 training hours as of the review date still had 9.7 hours to complete with only ten days remaining in her training year. Another staff was nine months into his training year and had only completed half of the required training hours. As a result of this observation, it is recommended that the program closely monitor the training calendar to ensure that the in-service staff are on target in completing the required training hours by the end of the required annual training period.

1.05 Interagency Agreements and Outreach

Satisfactory

Limited

Failed

Rating Narrative

The program has established a network of community partnerships and collaborations to ensure youth and families receive proper/appropriate services. As such, the program has a centrally located binder that holds all its Memorandum of Agreements (MOUs) and Interagency Agreements. Thirty-seven (37) such agreements were evidenced in the indexing with the agreements in place with prevention/intervention programs, universities, Broward County Schools, substance abuse and mental health providers, employment services, Broward County Health Department, medical services, translation, and other support services. All of the agreements reviewed were current and/or showed on ongoing renewal process.

The agency's Outreach Plan for FY 2011-2012 was reviewed onsite. The plan includes the provider's procedures for targeting high-risk youth and identifies informal/formal service partners, law enforcement, low-performing Elementary, Middle, and High schools located in high crime zip codes.

Although community outreach is a shared responsibility, the program has a designated staff person who is responsible for Community Outreach Activities. The Outreach staff coordinates the Safe Place Program and is responsible for recruiting sites as well as conducting presentations. The Clinical Supervisor/Counselor III maintains the interagency agreements as well as any community partnerships and collaborations.

LSF Broward also participates in the national Safe Place Program and maintains an outreach presentation log and outreach statistics on a monthly basis. There are currently 106 Safe Place sites located throughout Broward County including all the Fire Stations, Parks and Recreations Centers, Youth Organizations, and City Municipality offices. Over 1000 youth and 1600 adults have been reached through outreach activities since the beginning of the Fiscal Year. This information is documented in Netmis along with the dates of presentations, name/location of the presentation, purpose, and zip codes. The program conducts volunteer recruitment and currently has two Interns from Nova Southeastern University.

1.06 Disaster Planning

Satisfactory

Limited

Failed

Rating Narrative

The program has a comprehensive Disaster Plan as outlined in the indicator. The plan was updated and revised January 31, 2013 and the Fire Safety Plan was approved by the Fire Rescue Department on February 4, 2011. The Emergency Response Plan contained all the required elements including: 1) required types of emergency situations; 2) procedures to follow in a severe weather warning; 3) necessary equipment and secure transportation; 4) emergency contact list and emergency phone tree; and 5) notification procedures to the Florida Network and other funding agencies. Evidence was provided by way of email correspondence to the Florida Network to verify that the plan was submitted on February 20, 2013.

Employees are trained in emergency procedures during their orientation training and the majority of program staff had received Fire Safety training.

Fire drills are conducted by the program and are documented on a log and reports. Fire drills are conducted by staff on a monthly basis and on each shift, as required by the provider, and are completed within the required two minute timeframe. Corresponding reports provide details of each drill including an analysis and critique.

The program participates in the Universal Agreement for Emergency Disaster Shelter with the Florida Network Member Agencies and the Agreement was signed by the Program Director on February 14, 2012.

1.07 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedures for analyzing and reporting data for case record reviews, incidents, accidents, grievances, customer satisfaction, and outcome data. In addition, there is a comprehensive Lutheran Services Florida Continuous Quality Improvement Plan, FY 2012-2013, that includes detailed procedures to collect, review, and report various sources of information to identify patterns and trends.

The agency delineates specific responsibilities for Program Directors, Managers, Supervisors, and staff in their service areas to ensure they are meeting compliance standards. The agency-wide CQI Steering Committee is responsible for coordinating the Regional CQI Councils who directly oversee the activities of five CQI Teams made up of regional staff. The five CQI Teams are as follows: 1) Incidents, Accidents, Grievance, and Safety; 2) Consumer Stakeholder Surveys; 3) Performance Measurement; 4) Case Review; and 5) Program Implementation.

In practice, the program's CQI program includes many activities that are conducted by all 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 at least monthly. Upon completion of each record review, a Peer Review Report is aggregated summarizing the results and a copy of the report is provided to the program supervisor to address deficiencies. Program supervisors ensure appropriate follow-up is taken by their staff and responded to in a timely manner.

The program's Safety Team is made up of staff from the Residential and Non-residential program and is responsible for reviewing incidents and accidents, performing safety checks and fire drills, and making recommendations to management. Per the Sr. Administrative Assistant, the committee meets quarterly which is less frequent than the monthly meetings stated in the agency's CQI Plan. The team reviews incident reports, emergency and fire drills, facility safety checklist, vehicle inspection checklists for the preceding quarter. Meeting minutes of the last two quarterly meetings were reviewed and included a summary of the findings, attendance sheet, and supporting documentation.

Consumer grievances are reviewed along with the Program Improvement/Performance Team. The team has met monthly for the past three months to discuss program performance and a report is written summarizing the meeting. The agency CQI plan also includes client grievances; however, these were not being discussed or included in the team meetings.

The provider has a Performance Measurement Team to review statistical performance data and outcome measures. The outcomes data incorporates requirements of the contract, Netmis, and program outcomes required by the Florida Network and DJJ QI. The provider has a strategic management team that met in the summer of 2012 to discuss issues and programmatic strategies. No additional meetings of the team has occurred since then and evidence of a review of statistical performance data and outcome measures during the past six months could not be ascertained.

The provider has a Consumer Stakeholder Survey Team that reviews consumer surveys and report on their findings. The team's last meeting report was in February 2012.

The provider has experienced staff turnover including the vacancy of the Shelter Manager's position for two months. Consequently, most of the committee meetings were not occurring as required by the agency's CQI Plan. In addition, the focus of the Performance Team needs to be consistent with the guidelines of the agency's CQI Plan which includes a review of statistical performance data and outcome measures.

The provider reviews Netmis data on a weekly basis but formal procedures were not included in the program's Policy and Procedures.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

LSF Southeast is contracted to provide both shelter and non-residential services for youth and their families in Broward County. The program provides centralized intake and screening twenty-four hours per day, seven days per week, and each day of the year. Trained staff are available at each program site to determine the needs of the family and youth. Upon referral, a screening for eligibility is conducted and the screening is the initiation of the assessment process. Information regarding the youths' presenting problems, living situation, etc. is collected. Upon intake into either program (residential shelter or non-residential services), a more thorough assessment is completed. After all assessments are completed, the assigned counselor develops a case services plan with the family during the initial family session. If the assessment indicates the need for a referral to a more intensive or specialized service such as substance abuse or mental health treatment, the counselor makes the necessary referral for service. After the development of the case service plan, the counselor works with the family to implement the plan. Counselors document progress towards completion of the service plan goals.

The Broward Family Center 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 meets monthly and files the CINS Petition with the court, as recommended by the CSC.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The provider has a written policy and procedures in place. Time frames for the initial screening for eligibility to occur within (7) seven calendar days, of receiving the referral, by a trained staff member was included in the procedures. The procedures also included the responsibility of staff to provide the youth and parent/guardian in writing, during the intake, available services options, rights and responsibilities of youth and parent/guardian, grievance procedures and information on the CINS process in regards to the Case Staffing Committee, CINS Petition and Adjudication.

A total of six files, three residential and three non-residential, were reviewed. Intake assessments were completed the same day as the referral. Five (5) out of six (6) files contained consent for services. All six files reviewed reflected eligibility screening within 7 calendar days of referral. All 6 files reviewed contained evidence of grievance procedures and rights and responsibilities of youth and parents/guardians. However, two of six files were inconsistent with intake paperwork. For example, one residential file was missing a completed CINS/FINS intake form; the Counselor recreated a new form and provided it at the time of review. In addition, one residential screening form did not have all sections completed and one file missed completion of the substance abuse screening section.

None of the three residential files reviewed contained evidence that parents/guardians receive the parent guardian brochure in writing or the available service options. However, two of the three residential files contained progress notes that this was discussed with parents at intake. After interviewing the counseling staff it does not appear that there is an acknowledgement of receipt that is provided to the parent/guardian for their signature. Also, one out of six files did not contain evidence, in the progress notes or signed acknowledgment of receipt, that the availability of services for involvement with CINS/FINS services was provided to the youth/guardians.

2.02 Psychosocial Assessment

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy and procedures in place. The psychosocial assessment forms include all relevant social, emotions, education, health, substance abuse, behavioral concerns, employment, prior abuse or neglect, and family history information and a copy is placed into the youth's file.

A total of six files, three residential and three non-residential, were reviewed. All of the six files contained a psychosocial assessment evidenced by completion and signatures of bachelor's or master's level staff. Similarly, all of the six files contained a supervisor's review signature upon completion.

The three non-residential files had all sections of the psychosocial assessments completed. However, one of the assessments was inconsistent and did not document identified suicide risk and the file did not contain a full suicide assessment as a result of elevated risk identified in the psychosocial assessment. Information and/or history was provided and each section appeared to include involvement from all parties being interviewed.

Residential file psychosocial assessments were noticeably different in quality and content compared to all sections being completed in non-residential psychosocial assessments. Some sections of the residential psychosocial assessments were left blank or incomplete. Additionally, all psychosocial assessments in the residential files appeared to be completed with youth only and no documentation of parent/guardian input being interviewed at time of completion was evident. As a result, the assessments were observed to have insufficient or limited information regarding family history, DCF involvement, etc. being obtained from the parent/guardian, which may have impacted on the quality of the assessments and identified needs.

Three of the six psychosocial assessments are signed as completed but are missing completion of certain sections such as documenting if there is an elevated risk of suicide.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The provider has a policy and procedures in place. The procedures outline who is involved in developing the service case plan. For both the residential and non-residential programs, the youth, parent/guardian, and counselor are responsible for developing the service/case plan. The service plan is to be developed within (7) seven working days of the completion of the Psychosocial Assessment.

A total of six service plans were reviewed for three residential and three non-residential files. Five of the six files reviewed contained service plans, 2 residential and 3 non-residential files. One file was not applicable due to recent admission into program. Although the five applicable files contained service plans, there were findings that suggested inconsistencies in the plan development date, lack of participation by the parent/guardian, and incomplete information or inadequate goal development on the plans. These findings are described below:

Four of the five applicable files reviewed showed evidence the service plan was developed within 7 working days of psychosocial assessment but the progress notes showed conflicting information regarding the date of the service plan implementation in two of the files. All of the applicable files contained evidence of youth, counselor, and supervisor signature on the service plans. Similarly, all of the five files contained evidence of a parent/guardian signature on the service plan; however, the parent/guardian signature was pre-dated at the time of intake and prior to service plan creation in four of the five reviewed files. For example, one of these files showed an initial service plan completed in the file; however, a progress note dated 1/20/13 states treatment plan is to be created with youth at the next session. Per the explanation provided onsite with a interview with the Counseling Supervisor, the process currently in place is to obtain a parent/guardian signature for the service plan at intake prior to the creation of the service plan. This reviewer was unable to assess if the parent was a participant in the creation of their service plan based on the different dates of entered in the progress notes and the date listed on the service plan.

Four of the five applicable files showed evidence of service type, location and frequency on the service plan but one of the files did not show evidence that location was documented and one was missing the person responsible. Also, the target goal date for goal #3 was missing from one of the service plans and three of the files reviewed were inconsistent in documenting target dates.

Two of the five files showed evidence of individualized and prioritized needs and goals that were documented in the service plan as identified in the psychosocial assessment but two files did not identify truancy as a goal in the service plan although this was indicated in the reason for referral and psychosocial assessment.

Three of the four applicable files showed evidence that the service plan was reviewed for progress/revised by counselor every 30 days for the first three months.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy in place for this indicator. However, the policy lacks clarification on how counselors are documented and/or assigned to cases. The policy discusses counselors demonstrating numerous attempts to engage the family in the service delivery process but this was not always evidenced in the residential file progress notes. It appeared that the youth would be interviewed without parents/guardians to complete assessments, which is not in agreement with the provider's internal policy.

Four of six files reviewed showed evidence of the assigned counselor/case manager in the file. This was unclear in two of the files because it was not documented in the progress notes or Netmis. Four of the four applicable files showed evidence of staff providing support to families when they were contacted by the families and three of these files showed evidence that the counselors monitored the family's progress in the progress notes. Referrals were made when necessary and four of five files showed appropriate referrals were made for additional services. However, one file did not address suicide risk with referrals or services based on the intake information. Two files that were identified as needing case staffing referrals contained evidence that the referrals to the case staffing committee were completed. Five of the six files showed ongoing case monitoring.

It was documented in the progress notes that during counseling session (1/16/13) youth reported alleged abuse from step father which was reported to the abuse hotline and CCC. In addition, the mother communicated concerns about risqué photos youth posted on facebook but it was not apparent that subsequent individual sessions discussed safety or appropriate boundaries.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy in place. While the policy#2.05 addresses counseling services, there did not appear to be a procedure in place to clarify the internal process for ensuring the clinical reviews of case records by the supervisor, youth management, and staff performance regarding services. Counseling staff interviewed during the review appeared to be caring and interested in providing quality services to clients. During interviews, counselors asked for feedback to improve service provision and recommendations to improve current practice.

The Clinical Supervisor explained during an onsite interview that supervision is provided on a case by case basis and more critical cases will receive supervisory review. It was explained that counseling staff and interns may receive supervision from different resources. There is no current policy in place to provide an ongoing internal review of cases.

Each youth is assigned a Counselor and counseling services were provided in three out of four applicable case files in accordance with the service plan. The three files contained case notes that documented the counseling services provided and document the youths progress in services.

None of the six files reviewed showed evidence that an ongoing internal process is in place to provide case reviews.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policies and procedures in place that meet all of the requirements of this QI indicator. These policies can be found in Section II under policy 2.06 (Note: agency policies mirror the QI numbering system).

The program's Case Staffing Committee (CSC) consists of five primary members: the LSF Clinical Supervisor, an agency Counselor, a School Board member, a Mental Health representative and the CINS Attorney (by phone). The CSC meets regularly on the third Wednesday of each month at the LSF administrative office conference room.

A review of two open CSC cases was conducted during this site visit. Both files contained all of the required documentation including notification of both the youth/family and committee members, a CSC Report of the specific findings in each case, a CSC summary of recommendations, and a revised service plan as a result of the CSC meeting. All documentation related to notifications and outcomes met required time frames.

The outcome of the CSC meeting can be: recommendations, revision of the service plans and referral for additional services (Mental health, substance abuse or school related issues). The filing of a CINS Petition may also be recommended if the case indicates the need for the legal process to continue forward. Approximately twelve cases have gone to the CSC and about six cases have gone to the CINS petition level in the past 10-12 months.

Interviews were conducted with the Residential and two Non-Residential counseling staff about the case staffing process; however, the Residential Counselor was not aware of the case staffing process but provide evidence that information is given to parents that includes written guidance on the case staff process. The two Non-Residential Counselors indicated that they are aware of and are very familiar with the CSC process. They were able to clearly define and describe how the process works, who is involved, and what the requirements of the CINS Petition legal process are.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

A total of six files for residential and three non-residential youth were reviewed. Each youth has a separate file that contains information from the referral to case termination. The Residential and Non-residential files are organized differently but were consistently organized according to file checklist for each program. All of the files are marked confidential and are filed in secured file rooms.

Standard 3: Shelter Care

Overview

Rating Narrative

LSF Southeast operates its residential program, Lippman Youth Shelter, at 221 NW 43 Court, in the City of Oakland Park in Broward County, FL. The shelter is a twenty bed facility, licensed by DCF through 6/27/13, that provides residential services to youth in the Department of Juvenile Justice (DJJ) CINS/FINS program. The contract to provide services to youth from the Department of Children and Families (DCF) was terminated by Lutheran Services in the past year. At the time of the quality improvement review, the shelter was providing services to eight DJJ youth. The shelter is not designated by the Florida Network to provide staff secure services and is not licensed under Chapter 397.

Clinical services are supervised by a licensed LMFT-PhD Supervisor. Services provided include individual, group and/or family counseling, and any other applicable intervention required. The youth admitted to the program are screened using the Network Management Information System (NETMIS) Youth Screening Form, the CINS/FINS Intake Form, and a brief FAM (Family) General Scale. If a youth answers "yes" to any of the six questions pertaining to suicide risk on the CINS/FINS Intake form or if the staff member's observations of the youth's behavior would indicate any area of concern, an Assessment of Suicide Risk (ASR) is completed. The ASR is completed by either licensed professional or a non-licensed counselor under the direct supervision of the LCSW. A medical and mental health alert system is in place and the shelter staff that administers medications have been trained in the distribution of medication.

The provider identified the following External Control Factors during the review:

1. The program has experienced an excessive amount of turnover of key staff in the last 6-12 months which has impacted program operations, performance and consistency.
2. The program has had recent zoning issues with the City of Oakland Park that has caused some program changes and disruptions (storage of chemicals and tools, youth admissions, agency contracts, etc.).
3. As is true with most if not all CINS/FINS programs in Florida, the facility lacks adequate funding for a nurse or medical support services to monitor youth medical issues, conduct follow-up, and manage medication distribution.

3.01 Youth Room Assignment

Satisfactory Limited Failed

Rating Narrative

The agency has a policy in place that addresses all of the key requirements of this indicator. The policy manual is reviewed and updated annually by the Shelter Program Manager, the Clinical Coordinator, and the Executive Program Director.

During the shelter intake process youth are assigned a room by the Youth Care Staff completing the residential intake. Individual youth physical characteristics such as age, size, gender, and any disabilities are identified and behavioral issues such as history of aggression, risk of suicide, sexual activity and potential for absconding are evaluated.

These findings are documented on the CINS Intake Form located in Section I of the client case file. In addition, the agency completes a written "Anti-Damage Agreement" regarding the condition of the room to which they are assigned that also contains a room/bed assignment section.

A review of 5 client case files (3 open, 2 closed) indicated that in The CINS Intake Form and the Anti-Damage Agreement Form were filled out in each of the five cases.

There was one file that did not indicate a room or bed assignment even though the forms mentioned in the review of this indicator were in fact completed at intake.

3.02 Program Orientation

Satisfactory Limited Failed

Rating Narrative

The agency has a policy in place that addresses all of the key requirements of this indicator. The policy manual is reviewed and updated annually by the Shelter Program Manager, the Clinical Coordinator and the Executive Program Director.

The program has a comprehensive and detailed orientation process for youth being admitted to the shelter. The orientation process is documented on an "Orientation Checklist Form" that identifies 18 specific areas of program operations that are reviewed with each youth at intake. This form is signed and dated by the youth and the staff conducting the intake/orientation.

The Parent, youth and staff also sign a separate form stating that the youth has received the Client Handbook explaining program services, rules, rights and responsibilities.

A review of five client case files (3 open / 2 closed) revealed that the agency effectively completed the orientation process with each youth and also consistently documented this process in each case file.

No exceptions were noted at the time of this review.

3.03 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place that addresses all of the key requirements of this indicator. The policy manual is reviewed and updated annually by the Shelter Program Manager, the Clinical Coordinator and the Executive Program Director. There were 2 ADA posters posted for auxiliary aids and services. In addition, the facility had a 'highlights board' for staff to highlight accomplishments or give congrats to the residents in the common area/lounge. For example, the board highlighted "I love how you worked as a team tonight!"

The facility has current and satisfactory fire safety, food safety, and group care inspections conducted by the respective licensing authorities as noted below:

- The fire safety inspection was conducted by Oakland Park Fire Rescue on 5/10/12. Four minor exceptions were found and noted in the report.
- The food safety inspection was conducted by the Department of Health on 7/25/12. One exception was found and the facility was rated as satisfactory.
- The Group Care inspection report one minor exception and the facility was rated as satisfactory.

During the tour of the facility, the QI Team noted several physical plant deficiencies and safety issues that were identified and need to be addressed:

- One window glass pane was broken and needs to be replaced. The agency stated that this was a recent event and that estimates were currently being acquired to replace the window.
- Several walls/baseboards showed signs of water damage in resident bedroom/bathroom areas.
- Two mattresses and/or box springs in room #7 were damaged and need to be replaced. The agency indicated that there is a plan in place to replace them within the next 30 days.
- The window blinds were broken in most of the resident bedrooms. The agency stated that the new blinds have been purchased and are to be installed next week.
- A hole in room 10 was observed
- Wiring exposed below the 1st aid kit in the lounge was noted
- There were several hazardous tools being stored openly in the back yard near the building. The agency explained that the recent request by the City to remove a storage shed that was in the back yard led to this issue. The items were removed and stored safely during our tour.
- One of the agency vehicles used to transport youth had a worn out tire (right rear tire had metal belts showing). One vehicle was missing required safety equipment.
- There were a few resident bedrooms with signs of graffiti.
- The pool table needs to be repaired/resurfaced and the basketball hoops in the back yard need to be replaced.
- The exterior lawn maintenance was poor, recreation equipment was found scattered around the rear of the property and there was some trash and debris found on the grounds of the property.

The agency explained that there were some issues with a previous contractor and that they have established a new agreement with a new vendor to assist with facility and property maintenance. They indicated that many of these issues will be addressed or corrected within the next 30-90 days.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place that addresses all of the key requirements of this indicator. The policy manual is reviewed and updated annually by the Shelter Program Manager, the Clinical Coordinator and the Executive Program Director.

The program maintains a daily program log book to document program operations and daily activities of youth at the shelter. All staff review the log book upon arriving for duty at the facility. Staff reviews the log book up until the last time they were on duty at the facility and signs the log book to verify this process.

The log book contains the date and time of each entry and the signature of the staff member making the entry; all entries are legibly written in ink.

The log book contains documentation of the physical counts and location of youth currently residing at the shelter as well as critical client care information related to youth safety and facility security.

Some errors were not corrected according to policy and/or QI requirements. Also during the period October 2012-January 2013, there were some missing weekly supervisory reviews.

Rating Narrative

The agency has a policy in place that addresses all of the key requirements of this indicator. The policy manual is reviewed and updated annually by the Shelter Program Manager, the Clinical Coordinator and the Executive Program Director.

The program follows a detailed daily schedule to ensure compliance with QI requirements and general residential programming standards. There are separate schedules for weekdays and weekends and Holidays that detail the time, activity, and location of daily events.

The schedules include all required daily activities listed in this key indicator and are posted in the facility on a bulletin board located in the Day Room area of the facility.

Interviews with several staff indicated that the schedules are followed consistently in accordance with agency policy. The review made a recommendation that the program update the schedules to ensure accuracy and add copies to the Client Handbook.

3.06 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place that addresses all of the key requirements of this indicator. The policy manual is reviewed and updated annually by the Shelter Program Manager, the Clinical Coordinator and the Executive Program Director.

The program has a behavior management system in place to monitor, evaluate, and manage youth's behavior. The facility uses a daily point card to document positive and negative behaviors that are measured and given a point total value throughout the daily activities over each 24 hour period. The points are totaled on the overnight shift and youth are assigned to one of three levels based on their point totals: Gold, Silver or Bronze.

The levels are then posted on a dry erase board in the residential area for the youth to know what level they are on and what rewards, consequences or incentives they may have earned. There is one key staff member who is responsible for managing the reward and incentive system.

Each week the youth with the highest point total for the week is designated as the "Youth of the Week" (YOW) and their photo is placed on a bulletin board in the dining room of the facility. Youth on Gold Level or who earn YOW awards are given access to the "Canteen" (candy, treats and snacks) and the "Prize Closet" with special gifts, toys or other prizes.

Exception: The daily point levels were not posted on the dry erase board during the second day of our site visit.

3.07 Behavior Interventions

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place that addresses all of the key requirements of this indicator. The policy manual is reviewed and updated annually by the Shelter Program Manager, the Clinical Coordinator and the Executive Program Director.

Staff are trained in Techniques for Effective Aggression Management (TEAM), one of the approved curriculums by the Florida Network.

During our site review, surveys completed by staff and youth did not indicate any concerns or issues in this area. All youth surveyed reported that they felt safe at the facility and had not seen or heard any staff use verbal threats, methods of intimidation or profanity at the facility. Interviews with two youth care staff also supported and confirmed this information.

A review of youth grievances and incident reports also confirmed that the one major exception noted for this indicator appears to have been an isolated incident by one staff member who had not received the TEAM training as he was a relatively new employee. Therefore, the incident did not appear to be part of a systemic or underlying issue or problem at the facility. The incident occurred between a male staff member and a male youth at the facility. The staff member violated the use of force policy and the training guidelines and became aggressive/assaultive towards the youth. In initiating physical contact, the staff member violated policies and guidelines for behavioral interventions and was terminated from employment.

The agency did document and report the incident to local law enforcement, the DCF abuse registry and the DJJ CCC according to contractual requirements and QI guidelines.

3.08 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place that addresses all of the key requirements of this indicator. The policy manual is reviewed and updated on a regular and on-going basis by the Shelter Program Manager, the Clinical Coordinator and the Executive Program Director.

The program has a posted staff schedule that details staffing patterns during each week at the facility. There are three shifts: 7 AM-3 PM, 3 PM-11 PM and 11 PM to 7 AM. Each shift has a minimum of two staff to maintain the required 1:6 or 1:12 ratios during awake and sleeping hours at the shelter.

A review of the past three months of staff schedules revealed that there is a male and female on each shift and that a minimum of two staff on each shift for a maximum of 12 youth at any given time.

Even though the facility is licensed for 20 beds, interviews with two program supervisors revealed that the average daily census is between 8-12 youth. If the census goes above 12 youth then the facility would utilize a list of on-call, part-time staff to add additional coverage to ensure compliance with the staff:youth ratios.

An interview with program supervisors indicated that there were only a very few rare exceptions over the last 12 months when a male and female YCS were not on duty at the same time.

3.09 Staff Secure Shelter

Satisfactory

Limited

Failed

Rating Narrative

This facility/program is NOT contracted to provide Staff Secure Shelter.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The Lippman Youth Shelter has specific procedures related to the admission, interviewing and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. Upon admission, program staff will interview youth. An initial assessment occurs to determine the most appropriate room assignment, given the youth's needs and issues, the current population at the facility, physical space available and staff's assessment of the youth's ability to function effectively within program rules and expectations. Staff conducting the initial interview and assessment considers the youth's physical characteristics, maturity level, history including gang or criminal involvement, potential for aggression, and apparent emotional or mental health issues. Based on this information, the youth is assigned a bed which can change after further assessment. Room assignment is documented on the CINS/FINS Intake Assessment page 2.

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 Clinical Supervisor and Program Manager are notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented on Alert System Form that is maintained in a binder and is accessible to all staff.

Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission. Medications are stored in a double locked medication cabinet and topical and/or injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication ensures that an approved staff is scheduled on each shift. Medication records are maintained for each youth and stored in a MDR Binder.

4.01 Healthcare Admission Screening

Satisfactory
 Limited
 Failed

Rating Narrative

The program has a policy and procedure in place that address all elements of the indicator.

Three (3) files were reviewed for youth in shelter placement. The files of each youth included a preliminary health screening at the time of admission. The health screening is conducted during intake by the Youth Care Staff. The preliminary assessment included all of the indicators of the Health Care Admission Screening indicator.

4.02 Suicide Prevention

Satisfactory
 Limited
 Failed

Rating Narrative

The program has a policy and procedure in place that address all elements of the indicator.

Three (3) files of youth in shelter placement were reviewed. Of the three (3) files reviewed, the Suicide Risk Screening was completed during the initial intake and screening process in two of the files. The third file did not include a completed Suicide Risk Screening form. It is the agency's policy that each youth is screened for suicide risk in accordance with the Florida Network's Policy and Procedure Manual for CINS/FINS.

In review of the counseling notes in another file, it is noted that due to suicidal ideation, the youth would be observed throughout the night. In review of the log book, it is not documented that this specific youth was observed throughout the night. Further, upon admission, youth reported previous suicidal thoughts/attempts, but was placed on minimal level. This is inconsistent with the agency's Suicide Prevention policy. Other youth admitted with medication for mental health issues and allegedly previously Baker Acted with a history of suicide ideation and paternal suicide but was placed on Level 1. Again, this is contrary with the agency's policy for protocol to be utilized for medical/Mental Health assessments and requirement for sight and sound supervision.

It is recommended that the agency's completion and review of the CINS/FINS Intake Form incorporates compliance with all policies, procedures and practices, specifically, to ensure that the Suicide Risk Screening has been fully completed at the time of intake and screening. It is suggested that all levels of observation be documented in the log book. It is also recommended that agency follows policy relating to protocol to be utilized for Medical/Mental Health Assessments.

4.03 Medications

Satisfactory
 Limited
 Failed

Rating Narrative

The program has a policy and procedure in place that address all elements of the indicator.

All medications are stored in a locked room, within a locked cabinet and in locked containers as required by the indicator. There was no medication needing refrigeration as the program did not have any medication requiring refrigeration during the review period. However, a locked medication refrigerator is available in the medication room. The provider has a list of staff designated in writing to have access to secured medications.

The Medication Distribution Record (MDR) for one applicable youth was reviewed during the visit. The MDR contained the youth's name, date of birth, allergies, medication side effects, picture of the youth, staff and youth's medication initials, full printed name, signature, and title of each staff member who initials a dosage, and full printed name and signature of youth receiving the medication.

A controlled medication inventory record for the medication being distributed to the one applicable youth was maintained by the program. The inventory is conducted once on each shift and contains a perpetual count at the beginning and end of each shift along with the initials of staff and times the counts were conducted. Over the counter medications are inventoried on a weekly basis.

Kitchen sharps, grill tools, and emergency tools are maintained in secured containers and are inventoried daily.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure in place that address all elements of the indicator. Medical and mental health alerts are documented on a Shelter Alert System Sheet at intake and kept in a binder. The alert sheet documents the date and time of the alert identification or removal, all alerts, and risk factors pertaining to the youth during his/her stay. Kitchen staff is given a copy of special nutritional/food allergies and this is posted in the kitchen. The provider also has an alert's board indicating allergies such as residents having allergies to "bleach" and "shellfish". Food allergies were also documented on the board as one resident was allergic to "peanuts". The facility also indicated one resident having a 'mental health' diagnosis.

Three (3) files of youth in shelter placement were reviewed. Two of the youth had a medical or mental health condition and were appropriately placed on the respective alerts. The alert system included precautions concerning the medical/mental health conditions and review of the files document compliance with all the requirements of the indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure in place that address all elements of the indicator. New shelter staff are trained in CPR and First Aid and all in-service staff files reviewed maintained current certification.

Reviewed three (3) files of youth in shelter placement. Of the three (3) files reviewed, there was no documentation in the files to indicate that any of the youth had a need for emergency medical or dental care. A review of the emergency transport log provided included one emergency transport during the review period.

All staff are appropriately trained on emergency medical procedures as evidenced with interview of some of the staff.

Shelter staff have received appropriate training outlined in the policy and procedure for Episodic/Emergency Care; First Aid/CPR, use of knife for life and locations of First Aid Kits. Emergency telephone numbers are displayed throughout the facility, shelter rooms, common areas, and the dining area. The one emergency medical care incident was included on the emergency medical care transport log and in the log book.

Knife-for-life and wire cutters are located:

- in each of the vans (2 vans)
- mounted on the wall in the common area, behind youth care staff desk in a clear display box.

There are six (6) First Aid Kits located at the facility: two (2) in each of the vans; one (1) in the Kitchen; and one (1) in the common area.

In addition to having the First Aid kits in the vans and the common area, the agency also has a biohazardous disposal kit located in these areas. First Aid kits are inventoried weekly.

However, the First Aid kit located in the kitchen contained expired eye wash. It is recommended that the expired eye wash found in the First Aid Kit located in the kitchen be replaced immediately.