Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Miami Bridge-Homestead

on 11/04/2015

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	No rating

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

Standard 2: Intervention and Case Management	
2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 3: Shelter Care	
3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Special Populations	Satisfactory

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

Standard 4: Mental Health/Health Services	
4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	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:96.00%
Percent of indicators rated Limited:4.00%
Percent of indicators rated Failed:0.00%

Rating Definitions

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

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

Review Team

Members

Marcia Tavares, Lead Reviewer, Forefront LLC

Ivonne Fusco, Senior Administrative Assistant, Lutheran Services Florida SE

Ben Kemmer, Co-CEO, Florida Keys Children's Shelter

LaTerranance Reed, Case Manager, Urban League of West Palm Beach

Persons Interviewed

- [x] Program Director
- [ ] DJJ Monitor
- [ ] DHA or designee
- [ ] DMHA or designee

1 Case Managers
3 Clinical Staff
0 Food Service Personnel
1 Health Care Staff

0 Maintenance Personnel
1 Program Supervisors
2 Other

Documents Reviewed

- [x] Accreditation Reports
- [x] Affidavit of Good Moral Character
- [x] CCC Reports
- [ ] Confinement Reports
- [x] Continuity of Operation Plan
- [ ] Contract Monitoring Reports
- [ ] Contract Scope of Services
- [x] Egress Plans
- [ ] Escape Notification/Logs
- [ ] Exposure Control Plan
- [x] Fire Drill Log
- [x] Fire Inspection Report
- [x] Fire Prevention Plan
- [x] Grievance Process/Records
- [ ] Key Control Log
- [x] Logbooks
- [x] Medical and Mental Health Alerts
- [ ] PAR Reports
- [x] Precautionary Observation Logs
- [x] Program Schedules
- [ ] Sick Call Logs
- [x] Supplemental Contracts
- [x] Table of Organization
- [ ] Telephone Logs
- [x] Vehicle Inspection Reports
- [ ] Visitation Logs
- [x] Youth Handbook

4 Health Records
3 MH/SA Records
16 Personnel Records
7 Training Records/CORE
8 Youth Records (Closed)
3 Youth Records (Open)
4 Other

Surveys

4 Youth | 4 Direct Care Staff | 4 Other

Observations During Review

- [x] Intake
- [x] Program Activities
- [ ] Recreation
- [ ] Searches
- [ ] Security Video Tapes
- [ ] Medical Clinic
- [ ] Medication Administration
- [x] Posting of Abuse Hotline
- [ ] Tool Inventory and Storage
- [ ] Toxic Item Inventory and Storage
- [x] Discharge
- [x] Treatment Team Meetings
- [x] Social Skill Modeling by Staff
- [x] Staff Interactions with Youth
- [x] Staff Supervision of Youth
- [x] Facility and Grounds
- [x] First Aid Kit(s)
- [x] Group
- [x] Meals
- [ ] Youth Movement and Counts

Comments

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

Strengths and Innovative Approaches

Rating Narrative

Miami Bridge Homestead (MB Homestead), located in the city of Homestead in southern Miami-Dade County, is a Child in Need of Services and Family in Need of Services (CINS/FINS) program operated by Miami Bridge Youth and Family Services, Inc. The program is also a Staff Secure Shelter and is also a provider for youth referred through the Juvenile Justice Court System for domestic violence, probation respite, and domestic minor sex trafficking. MB is designated by the National Safe Place Program as a Safe Place provider who is responsible for building a network of safe place sites in the community to provide help and access to run away and homeless youth.

Miami Bridge is currently accredited by the Council of Accreditation (COA) and recently received re-accreditation through August 31, 2017. The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards.

MB Homestead's administrative office is located in North Miami, Florida, along with its north CINS/FINS shelter. The Homestead program serves both male and female youth between the ages of ten to seventeen years that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The emergency shelter offers a variety of services to meet the need of its target population. These services include: 24 hours a day, seven days a week shelter services; formal on-site education program with certified Miami-Dade County Public School teachers; structured daily living programs employing positive behavior modification techniques; mental health counseling; life skills groups to promote responsibility and independence; substance abuse prevention services; family reunification services and case management; positive youth development through recreation, arts, crafts and music; and health care coordination services to insure access to medical treatment.

Miami Bridge employs professionally licensed staff for both mental health and medical services. Its licensed Mental Health professionals provide oversight over its counseling services in both the residential and non-residential CINS/FINS programs at both program location in Miami and Homestead. In addition, there is a Registered Nurse who works at both facilities to oversee the referral for health care services and medication management of youth in care.

Since the last onsite monitoring visit, MB has appointed a new CEO, Dorcas Wilcox, and also promoted the former CFO, Steve Hope to a Deputy CEO position. The provider has completed substantial renovations and construction to the facility which includes:

- The addition of two bathrooms in the First Stop building
- Renovation of the bathroom in the School building
- Currently obtaining bids to upgrade the camera system
- Addition of televisions to the male and female dorm rooms
- Addition of four computers for the youth, courtesy of Braman Vehicles

This year, MB celebrates its 30th Anniversary since it was officially created as a 501(3)c organization in 1985. The celebration was hosted at the Central location and included entertainment, talent showcase by the shelter youth, arts and craft, music, sports, and food and refreshments.

Standard 1: Management Accountability

Overview

Narrative

MB Central, located at 2810 NW South River Drive, Miami, Florida, is under the leadership of a Board of Directors, Chief Executive Director, Deputy CEO/ Chief Financial Officer, Chief Operations Officer, Chief Administrative/Compliance Officer, and Clinical Director (2), and Director of Admissions. Dorcas Wilcox, Executive Director oversees the Miami Bridge program and the services provided through its two (2) service locations in Central Miami and Homestead, Florida. The residential component at each site is managed by Shelter Directors as well as Shift Leaders on each of the three shifts. The clinical component for each location is under the supervision of a Director of Clinical Services.

At the time of the quality improvement review, the program reported five vacancies for a Book Keeper, Janitor, Case Manager, Counselor, and Youth Activity Worker. The MB Homestead facility is licensed by the Department of Children and Families for 20 beds, with the current license in effect until February 29, 2016.

The agency handles all personnel functions of its 2 service locations through its Human Resources division located at its central office in Miami, Florida. This office processes all state and local background screenings and human resource functions. Annual training is tracked according to the employee's date of hire.

An individual training file is maintained for each employee, which includes supporting documentation such as sign-in sheets and certificates. The provider agency conducts orientation training to all shelter personnel through a combination of training sources that include the Florida Network, local area and in-house trainers. Each employee has a separate training file that contains a training attendance form and corroborating documentation for training received.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place that address the background screening of all employees and interns/volunteers prior to any offer of employment. The policy requires all staff and interns to complete a DJJ background screening (Live Scan), driver's license check and E-Verify for new employees confirming work eligibility.

A total of sixteen (16) applicable personnel files were reviewed for nine (9) new staff, five (5) interns, and two (2) staff eligible for 5-year re-screening. The nine (9) new staff were hired after the last onsite QI visit and all five received eligible screening results that were conducted by de Department of Juvenile Justice (DJJ) Background Screening Unit prior to hire. Similarly, the two staff that were eligible for 5-year re-screening had the re-screening conducted within the required timeframe prior to the staff's five-year anniversary date.

The program has five (5) interns providing service during the review period. All five received eligible screening results from DJJ prior to their service start dates.

In addition, Electronic submissions of Department of Homeland Security E-Verify for the 9 new employees were verified, confirming the employee's work eligibility.

The Annual Affidavit of Compliance with Good Moral Character Standard was completed and submitted on January 2, 2015.

No exceptions to this indicator were noted at the time of the visit

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Agency has a current policy and procedure in place for the provision of an Abuse Free Environment. The policy requires all employees to immediately report all allegations of child abuse or suspected child abuse to the Abuse Hotline. Staff are trained in these procedures during the first year of employment. In addition, the agency has policies on Code of Conduct, Dress Code, Grievance Process, Drug-Free Workplace, and Whistleblower policy to provide a safe place for its employees and clients.

During the tour of the facility the Reviewer observed posters with House Rules and Guidelines, Youth Rights and Responsibilities, Emergency Numbers and Evacuation Procedures in the hallway as well in the dorm rooms. There is some graffiti on the beds. A Grievance Box and binder are kept and a Monthly Abuse Registry Log and a Client Grievance Monthly Log are kept as well. During the last year there was six (6) abuse calls reported.

Regarding grievances, all clients receive an Orientation Guide and Grievance policy, procedure, and report form during admission. A confidential grievance box and forms are accessible to youth in the facility. In the past six months there were (15) fifteen grievances with final resolution and management review.

Exceptions

One of the four clients surveyed was not aware of the grievances procedure.

In the agency's policies and procedures it states that staff are trained to follow a code of conduct and staff signs off verifying receipt of the code of conduct in the Handbook; however, there was no documentation verifying staff were trained on it the code of conduct.

During the last year there was six (6) abuse call reported but, in 2 of the reports, the section to be completed by the client's assigned Residential Counselor was not fully completed.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has policy and procedures #1.03, Incident Reporting (Risk Management) that was last approved on 7/31/15. The policy and procedures clearly address the reporting and notification of reportable incidents to the Central Communication Center (CCC) within 2 hours of the incident or within 2 hours of becoming aware of the incident.

In a review of the CCC incident documentation for the past six months, there were three (3) incidents (one fire, one contraband, and one medical) reported between 5/1 - 11/4/15; all incidents were called in within the two hour frame required and for the Fire Incident they made an Administrative Corrective Action Plan.

There are no exceptions to this indicator at the time of the visit.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Agency has a written policy outlining Training Requirements for the first year of employment and for in-service staff. The policy complies with the requirements and procedures outlined in the Florida Network's Policy and Procedures and by the Quality Improvement indicator.

There were 3 (three) First Year Training files reviewed. One of them (DOH 6/15/15) has no program orientation, had not received nine out of the thirteen required trainings, and had completed only 23 of the 80 hours of training. A second staff (DOH 1/6/15) had not received mandatory training in Suicide Prevention, CINS/FINS Core, Signs and Symptoms of Mental Health and Substance Abuse and Professional Ethics. The third staff (DOH 7/21/15) was missing Medication Distribution for Non-Licensed Staff training and Professional Ethics. The latter two staff still had time to complete the required trainings and had completed 77 and 91 hours of training to date.

There were 4 (four) In-service training files reviewed; all four are missing Fire Safety Equipment and three are missing Suicide Prevention. These trainings can still be completed prior to the end of their training year. One of the four staff had exceeded the 40 hours required and the remaining three were on target for completing the required training hours.

The program maintains an individual training file for each staff that includes an annual tracking form and all related documentation as certificates and sign-in sheets.

Exceptions

One file has no program orientation that should be completed within 2-4 weeks and has not completed nine out of the thirteen required trainings, with only seven months remaining in the staff's training year. In addition, the staff had completed only 23 of the 80 hours of training during the first 5 months.

All four in-service staff are missing the mandatory Fire Safety Equipment and three are missing Suicide Prevention.

The majority of recommended trainings were not being offered by the provider.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Agency has a written policy and procedures for Analyzing and Reporting Data for Case Record Review; Incidents, Accidents and Grievances; Customer Satisfaction; Outcome Data, and Netmis data. It is the responsibility of the Chief Quality Improvement Officer and the QI Manager to oversee and coordinate the activities of the Committees.

In practice meetings are not been held consistently and the CQI minutes binder is disorganized. The reviewer was able to review the following reports:

Quarterly Case Record Review: Minutes for October 2015 showing review of data from January 1 - March 31, 2015. There were two subcommittee agendas for July and September 2015 that mentioned review of Case Record and Netmis Data.

Quarterly Review of Incident, Grievances and Accidents: Reviewer found minutes of March 2015 reviewing data of October-December 2014; Minutes for May 2015 reviewing January-March 2015 and Minutes for October 2015 reviewing an Annual report from July 2014 - June 2015

Annual Review of Customer Satisfaction: Minutes of March 2015 and a Review of FY 2014-2015

Annual Review of Outcomes: Minutes of May 2015 showing review of Outcomes from January-March 2015 and Minutes of October 2015 with review of Outcomes from April-June 2015.

Monthly Review of Netmis: Minutes for October 2015, September 2015, June 2015 and March 2015 but some have no attachments. Netmis data is only listed on the minutes as review of Netmis data. In addition staff interviewed stated Netmis data is reviewed and sent to staff via email. Proof of email submissions were not found for April, May, August, and September 2015.

Quarterly Review of Knowledge Portal of the Medication system: RN reviews medication inventories and discrepancies on a daily basis but not review of the Pyxis Knowledge Portal.

Exceptions

The information provided doesn't indicate the agency is reviewing CQI data in a timely manner in accordance with their policy. Data for the most recent quarter completed (July-September 2015) was not available as of the date of the QI review for Incidents/Grievances/Accidents, Outcomes, and Case Record Reviews.

Proof of email submissions on a monthly basis for review of Netmis Data was not provided for April, May, August, and September 2015.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Agency has a transportation policy that is implemented by agency approved drivers. A list of approved agency drivers sent by the administrative personnel is kept in a separate binder. The same binder keeps a daily van accountability log with all required information as time in and out, staff transporting, driver signature, destination, trip purpose, odometer reading, number of passengers and on the daily log is registered the outing with time, staff and clients names.

Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy. The insurance company is the one that runs the driver license report and sends it to HR, who keeps a binder with all information.

Agency policy indicates procedure regarding ratio and a third party present when transporting 1 client and includes exceptions in the event that a third party is not present in the vehicle when transporting as well as consider the client's history, evaluation and recent behavior.

There are no exceptions to this indicator at the time of the visit.

1.07 Outreach Services

☐ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedures for Outreach Services and Interagency Agreements, 1.07, last revised 7/31/15.

The program participates in local DJJ board and council meetings and keeps a binder with monthly meeting minutes.

The program also maintains 43 (forty three) written agreements with other community partners that include services provided and a comprehensive referral process.

There are no exceptions to this indicator at the time of this visit.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Miami Bridge Youth and Family Services is contracted to provide both shelter and nonresidential services for youth and their families in Miami-Dade County. The program provides centralized intake and screening twenty-four hours per day, seven days per week status offenders that include runaways, truants, ungovernable and lockout youth. The program has an Admission's Director who is responsible for Intake and Admissions. Additionally, trained staff members are available to determine the needs of the family and youth. Residential services include individual youth, family and group services. Case management and substance abuse prevention education are also offered. Aftercare planning includes referring youth to community resources, on-going counseling, and educational assistance.

The clinical component of the program is under the supervision of a licensed Clinical Director. A total of two Non-residential Counselors, one Residential Counselor, and a Case Manager are responsible for providing counseling and case management services and linking youth and families to various community services.

Youth entering the Miami Bridge enter services through First Stop via the Director of Admissions. FSFF Counselors work with youth both in the First Stop office as well as in the community. A youth goes through an intake screening process, followed by an intake and a needs assessment. A service plan is developed within a week of the completion of the service plan. Case Management and counseling are provided to meet needs and goals developed through the intake/service plan process. Counseling and supportive services are offered to parents/guardians/family members as well. The First Stop offices seem to provide a safe and nurturing environment for youth and families to meet with counselors.

Residential counselors have offices adjacent to the primary common area were residential clients spend time, thus allowing youth to have easy access to counselors. Staffing of cases is done on a weekly basis and file reviews are done quarterly.

The First Stop non-residential program is responsible for coordinating the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court. However, the provider has not initiated case staffing for any youth during the review period and/or since the last onsite QI review.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Agency policy 2.01, Screening and Intake, addresses the requirement of QI indicator 2.01. Per the policy and procedures, Centralized intake services are available through the shelter program and are accessible 24 hours and 7 days a week. Intake Services include screening for eligibility, crisis counseling, information and referral. The initial screening for eligibility must occur within 7 calendar days of referral by a trained staff members using NETMIS screening form. During intake, youth and parent receive in writing: 1) Available Services Options, 2) Rights and Responsibilities of youth and parent/guardian, 3) Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) and, 4) Grievance Procedures.

A review of five Residential and three Non-residential files was conducted. The Eligibility Screenings were completed within 7 calendar days of referrals in all case files reviewed. Parent and Youth were made aware of their available Options Rights and Responsibilities of Youth and Parent/Guardian. The Parent Guardian brochure was given as well as available service options. In addition Parent and Youth were aware of possible actions occurring through involvement with CINS/FINS services for example: Case Staffing Committee, CINS Petention, CINS Adjudication and Grievance procedures were signed by parent and youth. At the time of intake a CINS/FINS services brochure is given to the parent/guardian in English, Creole or Spanish, and the intake counselor reviews the brochure with the parent/guardian.

No exceptions were noted for this indicator.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Agency policy 2.02, Needs Assessment, provides for and reflects all the requirements of indicator 2.02. Per Policy 2.02, a Needs Assessment is completed to gather and analyze information for all youth receiving services. The assessment contains elements required by the Florida Network Policy and Procedure Manual for CINS/FINS which is: 1) initiated or attempted within 72 hours of admission, if the youth is in shelter care, or updated if most recent needs assessment is over six months old, and 2) completed within two or three face to face contacts following the initial intake if the youth is receiving non- residential services or updated if most recent needs assessment is over six months old

A review of five Residential files demonstrated that the Needs Assessments were initiated within 72 hrs of admission. Similarly, the Needs Assessments were completed within 2 to 3 face to face visits in the three Non-residential files reviewed. All eight Needs Assessments were signed by the Youth, Parent and Bachelors or Master's level staff. In addition, in one case reviewed with the Clinical Director, the youth was identified with an elevated risk of suicide during the assessment. The youth was referred for an Assessment of Suicide Risk that was conducted by a licensed mental health professional at Miami Children's Hospital.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider's policy and procedures include the following requirements of the indicator. Per Policy 2.03, a Case/Service Plan is developed with the youth and family within 7 working days following completion of the assessment. The plan is developed based on information gathered during initial screening, intake and assessment. The plan includes: 1) identified needs and goals, 2) type, frequency and location of services, 3)person(s) responsible, 4) target dates, 5) actual completion dates, 6) signature of youth, parent/guardian, counselor, and supervisor, and 7) date plan was initiated. In addition, the case/service plan is reviewed by the counselor and parent/guardian (if available) every 30 days for the first three months, and every six months thereafter, for progress in achieving goals and for making any necessary revisions to the case/service plans. When youth and/or parent/guardian are not available to sign the case/service plan, this is documented on the case/service plan and progress notes.

The Reviewer observed that Case Plans were developed within 7 working days and were individualized and prioritized in all of the eight files reviewed. As a result, all service plans contained 1) service types, frequency, location, 2) person(s) responsible, 3) target dates for completion, 4) actual completion date(s), 5) signature of youth, parent/guardian, counselor, supervisor, and date plan was initiated. In addition, all case plans were reviewed for progress/revised between the counselor and parent/guardian, if available, every 15 and 30 days according to file and Clinical Director for the first three months and every 6 months after.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Agency policy 2.04, Case Management and Service Delivery, provides for and reflects the requirement of Indicator 2.04. Per Policy 2.04, each youth is assigned a counselor/case-manager who will follow the youth's case and ensure delivery of services through direct provision or referral. The process of Case Management includes:1) establishing referral needs and coordinating referrals to service based upon the ongoing assessment of the youths/family's problems and needs, 2) coordinating service plan implementation, 3) monitoring youth's/family progress in services, 4) providing support for families, 5) monitoring out of home placement, if necessary, 6) referrals to the case staff committee, 7) recommending and pursuing judicial intervention in selected cases, 8) accompanying youth and parent/guardian to court hearings and related appointments if applicable, 9) referral to additional services, if needed, 10) continued case monitoring and review of court orders, and 11) case termination with follow up. The program is expected to comply with requirements and procedures outlined in the Florida Networks Policy and Procedure Manual for CINS/FINS.

In reviewing files, the Reviewer observed that each youth was assigned a Counselor/Case Manager. The Counselor/Case Manager established referrals needs and coordinated referrals to services based upon the ongoing assessments of the youths/family's problems and needs. The Counselor/Case Manager coordinated service plan implementation. Youth's/Family's progress was monitored. Support was provided for families; for example, one parent was down because of her child's actions that had him placed in the hospital and the Counselor provided support to get mother back on track and made a home visit to follow up. One case reviewed was referred to case staffing committee to address problems and needs of the youth and family. In one case, the youth and family were accompanied to related appointments by the Counselor. It was evident Youth/Family were referred to additional services when appropriate. Case monitoring was provided and case termination was provided with follow up.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Agency policy 2.05, Counseling Services and Family Involvement, provides for and reflects the requirement of Indicator 2.05. Per Policy 2.05, Youth and Families receive counseling services, in accordance with youths case/service plan, to address needs identified during the assessment process. Shelter programs provide individual and family counseling, as well as group counseling sessions held a minimum of five days per week. Non-Residential programs provide therapeutic community based services designed to provide the intervention necessary to stabilize the family in the event of crisis, keep families intact, minimize out of home placement, provide aftercare services for youth returning home from shelter services, and prevent the involvement of youth and families in the delinquency and dependency systems. Services are provided at youth's home, community location, or the local provider counseling office. When counseling services are offered, the case reflect coordination between presenting problems such as psychosocial assessment, case/service plan reviews, case management, and follow up. The program maintains individual case files with chronological case notes on youth's progress and adhere to all laws regarding confidentiality.

Eight files were reviewed for five Residential and three Non-residential youth. In reviewing files, Youth and family received counseling services in accordance with the Case plan. The Program provided individual/family counseling. Group counseling was provided at least 5 days a week for the five residential cases. Presenting problems were addressed in the needs assessment. Initial Case/ Case Notes were well maintained for all counseling services provided and youth progress was documented. In addition, an ongoing internal process is in place where the clinical supervisor reviews cases with staff and peer record reviews are conducted.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedures in place (2.06) that describes the Case Staffing process. Per Policy 2.06, a case staffing meeting is scheduled to review the case of any youth or family that the program determines is in need of services or treatment such as if youth/family is not in agreement with services or treatment or the youth/family will not participate in the service selected or the program receives a written request from the parent/guardian or any member of the committee. A Case Staffing committee is convened within 7 working days from receipt of the written request from parent/guardian. As a result of the case staffing committee meeting, the youth and family are provided a new or revised case plan for services. Within 7 working days of the meeting a written report is provided to the parent/guardian outlining the committee recommendations and the reason behind the recommendations. In addition, the program works with the circuit court for judicial intervention for the youth or family, as recommended by the case staffing committee. The program's Case Manager or designee completes a review summary prior to hearing, informing the court of the youth's behavior and compliance with court orders and providing recommendations for further dispositions.

One eligible case during the review period was reviewed. In this case, the petition was initiated by the parent (mother) and a case staffing was held within a 7 day time frame. In addition, the family and committee were notified 5 days prior to the staffing. The Case Staffing included all needed representation such as a local school representative, DJJ Representative, and CINS/FINS representative. As a result of the case staffing, the youth and family were provided a revised plan for services and a written report within 7 days of the case staffing showing the recommendations and explaining the reasons behind the recommendation. The program has a case staffing committee and according to notes minutes of meetings held, they have regular communication with the committee.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Per agency's Policy 2.07, the program maintains confidential records for each youth that contains pertinent information involving the youth and his/her treatment at the program. All records are marked "Confidential" and kept in a secure room or locked in a file cabinet that is marked confidential, which is accessible to program staff. All records that are transported are locked in an opaque container that is marked confidential. Youth records are maintained in a neat and orderly manner so that staff can quickly and easily access information. All youth records should be accessible only by program staff. Records should be organized for optimal information retrieval.

In reviewing the program's case files, all files were marked Confidential and kept in a secure room in a locked file cabinet that is marked Confidential. This file cabinet is accessible to only staff upon observation. Youth records are maintained in a neat and orderly manner so that staff can easily access information/file when needed. The program transports case files in an opaque container that is marked confidential and secured with a lock.

Standard 3: Shelter Care

Overview

Rating Narrative

Miami Bridge Homestead Shelter program provides temporary residential shelter care for male and female youth identified to be at-risk. The facility is comprised of three buildings: the main shelter building, a classroom building and the First Stop For Families building for non-residential counseling. The shelter is currently licensed by DCF as an emergency shelter for twenty beds. The program has adequate space for all activities and is equipped with one dormitory for male youth and one for female youth. The dormitories, kitchen, restrooms and common areas were clean during the tour of the facility. Each dormitory is further differentiated into Module A and Module B which is used to classify youth based on risk factors identified during intake. Youth are assigned lockers to store their personal belongings. Beds and lockers are numbered and youth are assigned to individual beds furnished with bed coverings and pillows. Youth have access to a large yard for outdoor activities.

Staff members in the Residential Program include: Director of Admissions, 1 Residential Counselor, a Case Manager, three Shift Leaders, nine Youth Activity Workers, a RN, a LPN Health Care specialist, a Food Specialist/Cook, a Recreation Specialist, and a Facilities Coordinator that is shared between the two shelters. The Direct Care workers are responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision. The Youth Activity Workers are also responsible for processing new admissions, providing orientation of youth to the shelter, and supervision of youth.

Health and medication related activities are the responsibility of the RN and Licensed Practical Nurse who maintain inventories on all sharps and medications, provides distribution of prescribed and over-the-counter medications, administer first aid when needed, and coordinates all offsite appointments to medical providers. Disaster plans, knife-for-life, wire cutters, and first aid kits are located in multiple locations throughout the facility, to include the staff station, medication office, and kitchen. All medications are stored in a locked cabinet in the staff office.

Oversight of clinical services is provided by Clinical Director. All youth admitted to the program receive a copy of the Client and Parent Handbook and an orientation to the facility. The program provides individual, group and family counseling, as needed. Group sessions are conducted five times per week and include: anger management, substance abuse prevention, nutrition, life skills, and social skills. Youth also received formal on-site education from Miami-Dade County Public Schools teachers and tutorial services. The program encourages family members to visit and to take part in the development of the youth's service plan. The program utilizes a variety of local medical facilities for emergency services. The shelter also admits youth from the Department of Children and Families (DCF). The shelter is designated by the Florida Network to provide staff secure services, Domestic Violence Respite, Probation Respite, and Domestic Minor Sex Trafficking services.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that outlines procedures to maintain a safe and clean shelter environment. An inspection of the shelter interior areas and exterior perimeter was conducted during this on site program review. The shelter is located in a Homestead which is a populated urban area of South Miami. The facility is licensed as a Child Caring Agency by the Department of Children and Families for 20 beds effective through February 29, 2016. The agency's Accreditation through the Council on Accreditation is valid through 8/31/2017.

The program is situated on a large well landscaped lot that includes the Emergency Shelter, administrative offices for Non-Residential staff, and on-site school equipped with Miami-Dade County instructors.

During the tour, the shelter was clean and well maintained although the age of the facility is prevalent. The grounds were well manicured and the garbage cans were emptied and had fresh linings. It was brought to the attention of the QI team that a Maintenance supervisor will be hired to maintain the facility. The facility has a large common area used for residential groups and a space for youth to relax during downtime. The program was donated several flat screen TVs to entertain the clients. The program is also experimenting with TVs in the client's rooms. While touring the facility it was noted the fire extinguishers were strategically located throughout the building and they were all updated with appropriate expiration tags. The facility also has a separate area for dining and a large commercial kitchen equipped with a large freezer and two refrigerators, one for the youth and one for staff.

The counselor's and staff offices are located in the main shelter off the common area and along one hallway that leads to the girl's dorm. Additional rooms in the facility include a family meeting room, a laundry room, and a Nurse's station. There are separate dormitories for the male and female residents. Each dorm area is furnished with five bunk beds, individual youth lockers; a loveseat; postings of rules, rights and responsibilities, expectations, important telephone numbers; and posters. The bathrooms were recently renovated to include: new showers, enclosed toilets, new sink vanities and new flooring. The camera system was nonoperational during the review.

The agency has record of the annual agency fire inspection that was completed by Miami Dade Fire Prevention Division on 2/5/2015 resulted in a violation stating the inspection, testing, and maintenance for fire alarm and fire detection system should be in accordance with Chapter 10. A satisfactory re-inspection was conducted on 2/9/15. A facility Biomedical Waste inspection was conducted 2/23/15 was void of any violations. The agency's last Food Service Inspection conducted 9/11/2015 did not cite any violations. A satisfactory Group Care Inspection was completed on 3/03/15.

Exceptions

During the two day review youth were observed watching TV on several occasions throughout the day. The program should add a variety of recreational activities to the daily schedule to prevent excessive nonproductive idle time.

Graffiti was observed on beds in the girl's dorm.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has an Orientation Policy and Procedures that covers details of the youth stay at the shelter such as program philosophy, goals, services, and expectations. This includes that each youth is given a list of contraband items, that each youth shall be informed of disciplinary actions, explanation of the program's dress code, accessibility to medical and mental health services,

explanation of procedures for visitation, mail and telephone, grievance procedure, disaster preparedness instructions, physical layout of the facility, sleeping room assignment and introductions, and suicide prevention precautions including alerting staff of their feelings or awareness of others having suicidal thoughts.

A review of four client files revealed that the Orientation process began on the date of intake and each client signed their orientation checklist sheet. Each youth was given a list of contraband items, an explanation of: disciplinary actions, the grievance procedure, emergency disaster procedure, rules on contraband, and a layout of the facility were given. They were oriented on room assignments, and suicide prevention precautions including alerting staff of their feelings or awareness of others having suicidal thoughts. Additionally, they received a review of daily activities; they were given and shown postings of the abuse hotline and a tour of the facility.

No exceptions were noted in the four case files reviewed.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has Policy Procedures related to room and bed assignment that includes an initial classification of the youth for purposes of room or living area assignment with consideration given to potential safety and security concerns. This includes but is not limited to: review of available information about the youth's history, status; initial collateral contacts; initial interactions with and observations or the youth; separation of younger youth from older youth; separation of violent youth from non-violent youth; identification of youth susceptible to victimization; presence of medical, mental or physical disabilities; suicide risk; and sexual aggression and predatory behavior. In addition the agency has a policy and procedure specifically addressing criminal street gangs.

The dormitories are broken down into two separate modules. Module A is for the younger, more vulnerable client while Module B is for the better adjusted youth. There is an island containing lockers, separating the two sides in the dorm and the staff supervising the unit is stationed on the Module A side for maximum supervision whenever youth are in their sleeping quarters. During the Orientation Process, the youth are informed of their bed assignments. The provider uses the CINS Intake Form for gathering information and observations of the youth at intake. Four open residential files were reviewed and all had completed CINS Intake Forms with Youth Room Assignments and classifications detailed. This form captures all required documentation for room classification. They also have a written policy on Medical and Mental Health Alerts. All four files had appropriate alerts posted.

A review of four youth active files confirmed that the program had a classification process in place to ensure the most initial appropriate sleeping room assignment for youth. All files include evidence of youth's general history, age, gender, history of violence, disabilities, conditions, illnesses, physical size, suicide risk, sexually aggressive, and alerts if applicable. All files are organized and review-friendly for easy identification of specific sections and documents. Each youth's file reviewed contained a CINS/FINS Intake Form signed and dated by a program's supervisor and staff that contained a Client Room Assignment section.

No exceptions were noted in the four case files reviewed.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a comprehensive Logbook Policy, #3.04, that requires: log book entries that could impact the security and safety of the youth and/or program are highlighted; entries to be brief and legibly written in ink and includes the date and time of the incident, event or activity, names of youth and staff involved, a brief statement providing pertinent information, and the name and signature of the person making the entry; recording errors to be struck through with a single line and the staff person to sign the correction prohibiting the use of whiteout; the program director or designee to review the facility logbook every week and make a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow up are required and signs/dates the entry. The incoming supervisor reviews the logbook of the previous two shifts to become aware of any unusual occurrences, problems, etc. and makes an entry signed and dated into the logbook indicating the dates reviewed to document the review. Direct care staff in the unit reviews the logbook for the previous two shifts and make an entry in the logbook and sign/date that they have reviewed it.

The Agency maintains a daily log book, bound with sequential pages, that includes entries from each shift. They have a color coded system for log entries which include Red, Green, and Blue/Black. All Red items are considered critical to the continued safety of the shelter or the youth in the shelter. It includes information on incidents, medications, medical appointments, grounds and facility checks, and alerts to Staff/Administrator for calls to CCC. All Green information pertains to Shift changes and current status/condition of shelter. It is also used to show Supervisor's review of the log. Blue/Black items are for head counts, visitors and general log entries.

A review of the log book showed where recording errors were struck through with a single line. The entries were legible and captured the overall shelter operation. The Quality Improvement Manager reviews the facility logbook weekly and makes a note in the logbook indicating the date reviewed and if any correction, recommendations and follow up are required and signs/dates the entry.

One exception to the indicator is noted. The staff do document shift change and staff turnover but do not specifically document that they have reviewed the log book for at least the previous two shifts as required by the standard and stated in the agencies policies and procedure.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The facility has a policy in place for the Behavior Management System. The policy states clear direction and expectation of the Behavior Management System and meets the requirements for this indicator. During the youth intake process, all residents receive a full explanation of the Behavior Management System (BMS). Information about the BMS is present in the client hand book. The process requires youth review and signature as acknowledgement.

The Behavioral Management System (BMS) being used by Miami Bridge-Homestead is a positive reinforcement model that accentuates and promotes acceptable behaviors by the youth. The

system consists of four levels. Orientation, Level I, Level II, and Level III. Point logs are kept and a client has to accumulate 100 points to advance to each level (i.e. it takes 100 points to advance from orientation to level I, 200 points from I to II and 300 points to advance to level III). An advancement in levels means the client receives more incentives.

The shelter maintains a cabinet filled with items for the clients to purchase with their earned points. It's equipped with clothing items, special food items, and an assortment of items that the youth can use. In addition special outings are used an added reward/incentive within the behavior management system. The Weekly Awards Ceremony acknowledges youth for their great efforts and behaviors and is announced in the Miami Bridge quarterly newsletter. Staff are oriented and trained in the theory and use of the BMS and evaluated in its use. Supervisors are trained in its use and to monitor staff's use of the BMS. Grievance reports are posted in the common area for easy access. Supervisors review all grievances with youth within 48 hours and with staff if applicable so that a resolution can be reached. Managing Aggressive Behavior (MAB) is the training curriculum that is currently used for physical intervention for personal safety and self-defense.

One exception is noted for this indicator because one staff training file reviewed did not receive Behavior Management Training.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place that meets all requirements of the standard. The agency has a weekly staff schedule that is developed by the Program Manager and is posted in the staff office in the shelter. The schedule includes youth care staff work hours/days over three shifts. The three shifts run from 6:30 AM to 3:00 PM, 2:30 PM to 11 PM and 10:30 PM to 7 AM. This provides for a 30 minute overlap between shifts to facilitate the transfer of information between staff working on different shifts.

The shelter is licensed for 20 beds and the staff schedules reviewed for the review period reflect a minimum staffing ratio of 1 staff to 6 youth during the afternoon shift and 1 staff to 12 youth during sleep period. The program had at least two staff working during the evening shift and always had a male and female on shift.

The program has an on-call roster that includes the names and telephone numbers of staff who may be accessed when additional coverage. A review of the program logbook shows that staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or when youth are in their sleeping rooms.

An exception to the indicator observed during the review is the program's non-functioning video surveillance system. Consequently, the Reviewer was unable to check camera footage to verify room checks. The Miami Bridge Board of Directors has approved funding to replace the surveillance system. Per Board policy the Board must bid the new surveillance system out to a minimum of three contractors due to the cost to replace the system. The Board is in the bidding process.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a detailed policy 3.07 for Special Populations that address the general requirements for this indicator. The written policy includes the procedures for staff secure, Domestic Minor Sex Trafficking, Domestic Violence Respite, and Probation Respite. Program staff are assigned shift to shift for (Special Populations) youth on the client roster board located in the staff office.

Three youth files were reviewed, one Staff Secure (SS) one Domestic Violence (DV) respite and one for Probation Respite (PR). The (SS) file reviewed showed there was a court order for CINS staff secure placement for a 90 day period. The file also contained documentation of prior approval from the Florida Network for placement. The case plan reviewed documented goals focusing on truancy intervention, communication skills, and other necessary interventions to reduce behaviors outlined in the Needs Assessment.

In the (DV) file reviewed, there was documentation of prior approval from the Florida Network for placement. There was also evidence the youth had a pending DV charge. The youth was transitioned to a CINS/FINS bed after twelve days. The case plan was reviewed documented goals focusing on anger management, coping skills, and other necessary interventions to reduce violence in the home.

The third file (Probation Respite) youth had documentation of prior approval from the Florida Network for placement. The youth was court ordered to shelter placement due to a "lock out "situation. There was documentation the youth was on probation with adjudication withheld. The youth was transitioned to a CINS/FINS bed after thirty days.

No exception to this indicator was found.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

MB Homestead 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 Module assignment, Module A or Module B, 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 Director and Residential Coordinator 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 the alert board, youth alert forms, and in the youth files using a color coding system. Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission. The provider has a RN and Health Care Specialist whose main responsibilities are the provision of medical care and medication management in the facility. Medications are stored in the Pyxis Medication Unit; topical and 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 written policy and procedures to ensure medical care for youth who are admitted to the program last updated July 31, 2015. The policy was updated to include that the Registered Nurse, the Licensed Practical Nurse, and Non-health care staff are required to perform preliminary health screenings at the time of admission to the shelter. The agency utilizes health screening forms that include the CINS/FINS Intake Form; Health-Related History Form; and Medical Services Consultation Form. All general client information is entered in the agency's client information system (CIS). When the RN is not on duty, the CINS/FINS Intake is completed by the Youth Activity Workers. The agency Nurses utilize the Health-Related History Form after the Intake process. This information is used to develop a health or medical summary for each client. The agency nurses also use a Medical Services Consultation Form.

Four residential case files were reviewed. The health care screening was conducted by the RN in all 4 of 4 files reviewed. The provider's preliminary screening form includes: current medications; allergies; existing medical conditions; allergies; observation for evidence of illness and injury; and presence of scars, tattoos. All four files reviewed contained the above mentioned screenings. Evidence of parental involvement in the coordinator and scheduling of follow-up medical appointments was found in three applicable files.

Exceptions were found during the file review for this indicator. The healthcare screening form included a question for whether or not the youth has been treated or hospitalized for any medical condition(s) in the last year but does not inquire if youth had any "recent injuries or illnesses".

Also, there is observation for evidence of current illness or injury but the health care screening does not capture observation of pain, physical distress, difficulty moving etc. or other skin markings as required by the indicator and the provider's policy.

In 3 of 4 cases reviewed, staff documented observation of tattoos and/or scars but did not provide an explanation, description of, or location on the youth's body in the comments section.

4.02 Suicide Prevention

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The shelter has a Suicide Prevention policy that is current. This policy includes the agency's suicide prevention and response procedures. The agency's suicide risk assessment policy has been approved by the Florida Network of Youth and Family Services. The policy requires that each resident admitted to the shelter will be screened for suicidal risk by the utilizing the six (6) suicide risk questions on the CINS/FINS Intake form.

The Direct Care staff are trained to utilize the CINS/FINS Intake form. If the resident answer "yes" to any of the 6 questions, the policy requires that resident be placed on elevated supervision (Constant Sight and Sound supervision) until a full suicide assessment can be completed by a qualified mental health professional. If the qualified mental health professional is not available, the youth will be placed on Constant Sight and Sound supervision until the counselor is available to conduct a full suicide assessment.

A review of three randomly selected closed case files serviced in the last 6 months was conducted to assess the agency's adherence to the requirements of this indicator. All client files reviewed were screened and deemed positive for suicide risk. All 3 client files had evidence that they had been screened for suicide risk during the intake process. Youth that were deemed positive were placed on sight and sound supervision until assessed by a licensed clinician or a non-licensed Master's level counselor under the direct supervision of the agency's licensed professional. Two of the three files contained suicide screening results that were reviewed and signed by a supervisor and the youth remained on sight and sound supervision until their status was reviewed and confirmed by the counselor under the direct supervision of the agency's licensed professional.

Exceptions were noted for this indicator.

- Three closed files were reviewed. The suicide screening results was not signed and dated by the supervisor in 1 of the 3 files.
- The supervision level was changed prior to completion of the Assessment of Suicide Risk by the clinician in one file.
- One of the precautionary observations was not conducted in the 15 minute timeframe required (7/23/15 at 9:25 pm then at 9:45 pm).
- The Mental Health Clinical Staff Person's signature and date was missing from the precautionary observation logs in two of the three files.
- None of the 3 files showed where the supervision level was recommended to be changed by the clinician in the progress notes or on page 2 of the observation log.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has written policy and procedures to ensure that residents that are admitted to the program are provided medication during their shelter stay. This policy was last updated July 31, 2015. The agency has updated its policy to include the mandatory use of the Pyxis Med-Station 4000 to store all prescribed medications. The policy also incorporates that a Registered Nurse (RN) is being authorized to administer medications and approved injectables medications.

The provider hired a RN, in July 2015, who works part time at the Homestead shelter and went live on September 1, 2015 with the Pyxis Med-Station 4000 Medication System. The medication cabinet is housed in the Nurse's office near the rear of the shelter building. All medications, with the exception of the over the counter medications (OTC), are stored in the Pyxis cabinet. The medication cabinet is stored behind a locked door and is accessible only to approved staff. The provider's list of fifteen approved staff has an effective date of October 2015. The agency has three Super Users for the Med-Station.

Oral medications are stored separately from injectable or topical medications as one bin is used for each medication. There were no injectable or topical medications during the QI visit. There is a small locked refrigerator in the medication room for medication requiring refrigeration; none were present at the time of the visit.

All narcotics and controlled medications are stored in the Pyxis cabinet which secures the medication behind two locks, a locked cabinet and locked bins, which is only accessible by staff approved and authorized in the system. A perpetual inventory with running balances of controlled substances is maintained on the medication distribution log as well as in the Pyxis system.

Over the counter medications are stored in a locked cabinet in the Intake office. A perpetual inventory is maintained on the inside of the door. Staff makes an entry each time OTC is given to a youth and document the perpetual inventory. Three of the OTC distribution records did not have a remaining balance documented by staff (10/8/15, 10/27/15, & 11/4/15).

Syringes and sharps are stored in a locked cabinet in the medication office. There were not syringes present during the visit. Weekly inventories are conducted by the Nurse or designated staff.

Medication distribution logs (MDL) are maintained in a single binder for all youth receiving medications. Each youth also has a separate medical file. The RN maintains both the MDL and medical files. The MDL for 3 youth were reviewed. MDL records include: youth's name, date of birth, allergies, medication side effects, picture of youth, staff and youth's initial for each medication record, full printed name, signature, and title of each staff who initials a dosage, and full printed, signature of youth receiving medication. The latter two are documented on page 2 of the MDL. Shift-to-shift counts are documented on the MDL in a section below the dosage distributions.

One exception to this indicator was noted. Three of the OTC distribution records did not have a remaining balance documented by staff (10/8/15, 10/27/15, & 11/4/15).

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has policy and procedures related to the medical and mental health process, last approved 7/31/15. The program has an alert system that ensures information about the medical, nutritional, substance abuse and mental health of each applicable youth is documented and communicated to staff. Alerts are provided to staff via color coded dots placed on the alert board in the intake office and in the youth's file using the following colors: prescription medication-red; mental health diagnosis-orange; substance use-blue; medical condition-red; nutrition-yellow; and victimization-green.

Observation found that the program maintained a current alert color coded board in the intake office and a special nutritional instructions food allergy alert in the kitchen. A review of four youth applicable residential files found that each file contained a color code behavior/medical alert that also includes the youth's medical grade classification system. One of the four youth also has a medication alert (receiving medication for a mental health diagnosis), but did not have the medical alert posted, only the mental health and substance abuse. The alert system form in the file captures information about the various alerts identified for the youth; however, the alert system form does not document precautions concerning prescribed medications or medical/mental health conditions providing information for staff to recognize/respond to emergency care if needed.

Staff surveyed indicated that they are informed of the youth's medical/mental health alerts through the alert form, the shift meetings, the log book, and the youth's files.

Exceptions were noted for this indicator.

One of the four applicable medical/mental health youth files reviewed has a medication alert where the youth is receiving medication for a mental health diagnosis; however, the alerts did not have the medical alert posted, only the mental health and substance abuse.

The alert system form in the file captures information about the various alerts identified for the youth; however, the alert system form does not document precautions concerning prescribed medications or medical/mental health conditions providing information for staff to recognize/respond to emergency care if needed.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has policy and procedures related to episodic/emergency care that was last approved on 7/31/15. An Emergency Preparedness Manual is accessible to staff and is located by the entry door of the facility. The program's procedures include the process for obtaining offsite emergency services, parent notification, reporting to the CCC and Florida Network but not development and implementation of a daily log or verification of medical clearance upon youth's discharge from a medical facility and return to the facility.

Training documentation reviewed found that 2 of the 3 new staff received training in cardiopulmonary resuscitation (CPR) and first aid and emergency response.

A review of four applicable youth files found that all the youth required off-site emergency medical care and in each case the parents/guardians were timely notified and the medical attention provided was documented utilizing the provider's Client Transported Offsite Due to Emergency Medical Attention's form.

Staff training showed that two of the three new staff received training in CPR/First Aid and Emergency response. The third staff was in their 4th month of hire and had not received these trainings to date.

During the tour of the facility, the reviewer observed the location of the knife-for-life and wire cutters to be located in the staff intake office. First aid kits are located in the two agency vans, intake office, kitchen, school site, and the Nurse's office.

One exception was noted for this indicator. The program's procedures include the process for obtaining offsite emergency services, parent notification, reporting to the CCC and Florida Network but not development and implementation of a daily log or verification of medical clearance upon youth's discharge from a medical facility and return to the facility.