



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of SM ACT Behavioral Health Center

on 10/21/2015

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

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

Rating Definitions

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

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

Review Team

Members

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Susan Spinella, Vice President of Quality Assurance, YCC

Al McCray, Shelter Director, Boys Town of Central Florida

Raylene Coe, Street Outreach Coordinator, Crosswinds Youth Services



Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 3 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 1 Clinical Staff | 2 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 0 Food Service Personnel | 0 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 | 5 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 5 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 6 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 4 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 4 Youth Records (Open) |
| <input checked="" type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- | | | |
|---------|---------------------|---------|
| 5 Youth | 4 Direct Care Staff | 0 Other |
|---------|---------------------|---------|

Observations During Review

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

Comments

Items not marked were either not applicable or not available for review.
[Rating Narrative](#)

Strengths and Innovative Approaches

Rating Narrative

The agency is currently in the beginning stages of planning to move the residential shelter to their Tiger Bay facility. All non-residential counselors have already moved. They are hoping to have the residential side moved within the next year. The agency is working on a big fundraiser initiative right now to help with the cost of the move.

The shelter has not had any probation respite youth since the last review; however, has had lots of domestic violence youth. All newly hired probation officers in the county tour the shelter so they are aware of the services provided.

Since the last review the agency has appointed a new C.E.O. and the former VP of Crisis of Residential Services has been promoted to the new C.O.O.

The non-residential portion of the program has remained consistent since the last review, with the exception of one new counselor, who was a former intern and already familiar with the program.

The shelters Basic Center Grant is still active and the street outreach services are in the last year.

The Director of the shelter is also the chair of human trafficking for Circuit 7.

The agency has a substance abuse rehab facility so youth with major substance abuse issues coming into the shelter can transition into their substance abuse rehab facility seamlessly.

Standard 1: Management Accountability

Overview

Narrative

Stewart Marchman ACT Behavioral Healthcare serves as the local service provider of Child in Need of Services and Families in Need of Services (CINS/FINS) in the Seventh Judicial Circuit that includes Flagler and Volusia Counties. The SMA Company provides both residential and non-residential Services. The SMA Company is a current local service provider under contract with the Florida Network of Youth and Family Services to provide CINS/FINS services. This contract serves youth that are considered status offenders, homeless and lockout youth. These services include entry level of intervention and treatment for youth and families that are at risk for legal complications such as chronic runaway, lockout from the home or repeated school truancy.

The SMA company operates the B.E.A.C.H. (Bringing Enrichment And Children Home) temporary youth shelter. The agency has a capacity of twenty (20) beds. A total of ten (10) beds are designated for youth that meet the eligibility requirements of CINS/FINS services. The SMA Company has been a Safe Place member and continues to be an official Project Safe Place site.

The management team consists of A Director of Adolescent Services, an Assistant Program Director, two Residential Shift Managers, four CINS/FINS Service Managers, one full-time Counselor, one part-time counselor, ten Youth Specialists, an Administrative Assistant, one Case Manager, one Outreach Specialist, and one Outreach Coordinator. The Program Director reports to the Vice-President of Residential/Crisis Services, who oversees all juvenile services provided by the Stewart-Marchman ACT Behavioral Services.

Training is provided through a combination of live in person instructor led courses, web-based training topics, and various approved off-campus seminars. The program has a Human Resource Director who oversees all background screenings, as well as other personnel issues. The program provides family, mental health, substance abuse, and behavior management services. The program has current operations and program policies and procedures. Further, the agency also conducts outreach services through partnerships with local community stakeholders and various system partners.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

Background screening files were reviewed for four new employees and one employee requiring a 5-year re-screening. All background screening documentation was received by agency prior to date of hire, and the 5-year re-screening, for the long-term employee, was completed prior to the 5 year anniversary date.

Annual affidavit for agency was completed, notarized, and sent to DJJ on January 5, 2015.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

Appropriate postings were found in common areas to ensure that clients were aware of their rights to abuse-free environment, including procedures to follow if abuse occurs. In addition, client handbook and program manual cover this topic thoroughly. There is a client grievance process in place, including blank grievance forms available in common area for easy access. Client handbook covers grievance process step-by-step.

It is noteworthy that there have been no client grievances within the past twelve months.

There are anti-bullying posters, posters that prohibit use of swearing, and posters that explain reasons for a dress code.

All four staff surveyed knew the procedures to allow a youth to call the abuse hotline. All staff also reported they have never heard another staff member deny a youth access to the abuse hotline. Three of the four staff also reported they have never heard a co-worker use inappropriate language when speaking with the youth or use threats, humiliation, or intimidation and one staff reported they have.

All five youth surveyed reported they know about the abuse hotline but have never called. All five youth reported they have not been denied access to call the abuse hotline if wanted. All five youth surveyed reported staff are respectful when speaking with the youth. Four youth reported they have not heard staff use inappropriate language when speaking with the youth and one youth reported they have. All five youth reported they feel safe in the shelter.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

Incident Reports were reviewed for past twelve months, October 2014 - October 2015. Read-out reports from CCC were compared to actual Incident (Occurrence) Reports written by staff. Incident reports reviewed included abuse allegations (against a parent), and suicidal ideation by client. All appeared to be documented well, and corresponded to CCC records.

There are specific guidelines in Program Manual explaining how to handle reporting of incidents.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

Training records on all staff were presented in a binder. Later, two new hires and random staff were selected for review. The training certificates and annual training printouts on these specified staff were provided to this reviewer.

Training requirements for staff were outlined clearly in program operations manual.

There were two first year staff and four long-term staff training files reviewed for total number of hours in addition to content of training completed. The two first year staff exceeded the number of training hours required and covered every topic. The long-term staff also exceeded their training hours and passed all required courses.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

Processes are in place to analyze, track, and report data. One avenue of reporting/tracking data is monthly meetings in which FL Network progress reports are discussed and trends analyzed. The following was noted:

1. Monthly review of NetMIS data reports
2. Monthly review of Performance Improvement Standards (FL Network)
3. Monthly review of Incident/Occurrence Reports
4. Monthly review of any Safety Concerns
5. Quarterly review of Case Record Review Reports
6. Quarterly review of Incidents/Accidents/Grievances
7. Annual review of client satisfaction data
8. Annual review of outcome data

The finding of all reviews are reviewed by management team and communicated to staff and other stakeholders. Strengths and opportunities are identified, and improvements or modifications implemented. Processes for review of MedStation are in planning stages, due to newness of acquiring this. Meeting minutes were reviewed to confirm that these topics were discussed and reviewed at quarterly QI/RM meetings and monthly staff meetings.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

Transportation logs were reviewed and contain necessary elements for recording transport of clients. The logs included purpose of trip, mileage to and from, staff name and dates of transport. There is a policy outlined in program manual which covers handling of situations in which youth or staff might be placed in danger. The presence of a third party in vehicle is strongly encouraged, and if this is impossible due to ratio or other reasons, the program manual noted the requirement of documentation and notification of program manager. The policy also explains how logs are to be maintained, and logs reviewed were consistent with this process.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

SMA Behavioral Health has a comprehensive policy regarding outreach, which includes the use of interagency agreements with a variety of community-based resources, juvenile justice, and law enforcement entities. Documentation of Safe Place participation was observed in the form of letters and certificates. Participation in a Human Trafficking Task Force was also documented.

Records were reviewed that document participation in a variety of outreach events in the community. Also reviewed were interagency agreements with local healthcare agencies, educational institutions, mental health facilities, and the local Outward Bound program.

Letters of support were reviewed from several community entities, including the local Domestic Abuse Council, Pace Center for Girls, and DJJ.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Stewart Marchman ACT Behavioral Healthcare (SMA) provides an array of services including Centralized Intake and Non-Residential Counseling services. The non-residential staff members include a Licensed Clinical Beach House Counselor, and four (4) CINS/FINS Service Managers. Non-residential services are provided to program participants and their families. These non-residential services are delivered through the agency's non-residential component and are provided twenty-four hours a day, seven days a week.

After intake, the program's Bachelor's or Master's level staff completes a needs assessment on each youth within 72 hours of admission or, completes such an assessment within two to three face-to-face contacts for youth receiving non-residential services. These assessments are reviewed and signed by a supervisor and, if there is a suicide risk component of the assessment required, it is further reviewed by a licensed clinical supervisor or written by licensed clinical staff. Within seven (7) working days after the completion of the assessment, the program develops a case/service plan with the youth and family.

Each youth is assigned a counselor/case manager who will follow the youth's progress on the case/service plan to ensure the delivery of services either directly or through referral. Case/service plans are reviewed by the counselor/case manager and parent/guardian (as available) every 30 days for the first 3 months, and every six months thereafter, for progress in achieving goals and for making necessary revisions to the case/service plan, if indicated. Youth and families receive individual, family and group counseling services, as set forth in their case/service plan, from program staff who document coordination between problems presented, and the youth's psychosocial assessment, case/service plan and reviews thereof, case management and follow-ups. Individual case files are maintained in accordance with confidentiality laws and notes kept chronologically in order to track progress. The program also has an established internal process to ensure clinical review of case records, case management, and staff performance.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The program has a centralized intake and, according to its policies and procedures, the shelter services are available and accessible twenty-four hours a day, seven days a week as required by this standard indicator.

This reviewer looked at four (4) open residential youth/client files and (4) open non-residential youth/client files. Each residential youth/client file contained a section entitled "Consents/Requests". Within this section, the program provides the following forms completed and signed by the youth and their parent/guardian (as appropriate) at Intake: Rights and Responsibilities, Authorization for Services with Informed Consent, Consent to the Use of Protected Health Information, Basic Consents & Authorizations, Youth Prevention Services Values, Inventory of Personal Effects, Orientation Checklist, Consent to Participate in Outings, Informed Consent For Participation in Post-Discharge Activities, House Rules, School and Van Rules.

Within the Orientation Checklist form is a record of each youth/client receiving an "Orientation Packet" that contains information about the program's Grievance Procedures and the House Rules and School and Van Rules forms from that packet are required to be signed by the youth/client and included in each youth/client file. There is also a section in each youth/client file named "Title IV E" which contains a form signed by the parent/guardian of each youth/client for "CINS/FINS Shelter Voluntary Placement Agreement". Each parent/guardian acknowledges that they have received a Florida Network CINS/FINS Brochure that outlines the services available and the possible actions that could occur through involvement in the program.

Each youth file contained a completed Florida Network NetMIS Screening appropriately signed by both a Residential Shift Manager and the CINS/FINS Program Director or Assistant Director.

Although the non-residential files did not have a tab entitled consents, each of the four (4) files reviewed contained signed consent forms indicating that the youth/client and their parent/guardian (as appropriate) received information about the available service options, rights and responsibilities, possible actions involvement in the CINS/FINS that could result and grievance procedures as required by this indicator.

During a tour of the facility, this reviewer observed prominent display of grievance procedures in several locations though-out the shelter facility, as well as accessible grievance forms. As noted above, the Grievance Procedures are reviewed with each youth/client at Intake and program staff record this on the youth/client's Orientation Checklist.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place at page 51 of its Policies and Procedures Manual that sets forth that psycho-social needs assessments be done within 72 hours from intake of a youth/client into residential shelter and at first face-to-face visit/session for a non-residential youth/client with completion within three (3) face-to-face visits/sessions.

This reviewer looked at the same four (4) open residential youth/client files and (4) open non-residential youth/client files to determine whether the requirements of this indicator were being met by the program.

Each youth/client file contains a Biopsychosocial Assessment (a/k/a Needs Assessment) and, as required by the indicator and the program's policies, all of the files reviewed show that these assessments were completed by a Bachelors or Master-level staff member within 72 hours of admission for the residential files and at the first face-to-face visit/session for the non-residential intakes. Each Assessment was appropriately signed by a supervisor, as well. None of the files reviewed contained an additional suicide risk screening.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy that requires a service plan be created based on the service needs identified in the psycho-social needs assessment.

The four (4) residential files reviewed reflected that each youth/client had a timely needs assessment (a/k/a psycho-social assessment) done within seven (7) working days from intake in compliance with this indicator. Most of the four (4) non-residential files reflected that the psychosocial assessments were done contemporaneously with intake at the first face-to-face visit/session. One exception where the assessment on a non-residential youth/client that was done in April was the basis for a case plan created in July when the case was re-opened is still within the permissible requirements of this indicator.

The reviewer notes that all the case plans were properly signed by the youth, parent/guardian, counselor and supervisor. In the four (4) residential files, the frequency of services was rather general (e.g. "all group sessions") and the location where the services are to be rendered is implied to be the shelter rather than explicitly stated. Also, the computer system entitles the service plan as a 'Master Report', which required the reviewer to ask for assistance in identifying it as the required case plan. Overall, however, the service plans reviewed were clearly acceptable in providing identified needs and goals; the type, frequency and location of services; persons responsible for helping the youth/client meet their service plan goals; the target date of completion; signature of the youth/client, their parent/guardian, the program counselor and program supervisor; and the date the service plan was initiated.

Each file that was over thirty (30) days old, of which there were only three (3) non-residential, contained the proper review of the service plan and signature of the youth/client and parent/guardian when available. In every instance where a youth/client and/or parent/guardian signature was not obtained, the case manager noted the reason in the file as per the program's policy. (The other open non-residential file had not been open for 30 days.)

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place to ensure appropriate case management and service delivery in accordance with this indicator.

Four (4) residential and four (4) non-residential files were reviewed. A counselor/case manager was assigned to each youth/client and provided referral services, coordination of services, monitoring of progress, family support, and reviews as required (or appropriate). Of the eight (8) files reviewed, five (5) were referred for substance abuse services. There were no instances requiring the assigned counselor/case manager to monitor of out-of-home placement, or to accompany a youth/client and their parent/guardian to court hearings or related appointments.

The reviewer was provided three (3) case staffing specific additional on-residential files, which indicated that the program does provide case monitoring, referrals, and case termination follow-ups in these instances. The program requires follow-ups at 30, 60 and 90 days to assess progress and adjust service delivery as necessary for these clients, as well.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

Since the program provides clinical counseling services, it has a policy in place requiring "chronological case notes on youth's progress" in addition to an "on-going internal process that ensures clinical reviews of case records, youth management, and staff performance regarding CINS/FINS services." This policy conforms to the requirements of this standard; however, because the program currently has only one (1) clinical staff member, the indicator requiring clinical reviews of case records, youth management, and staff performance appears to be 'NOT APPLICABLE' at this time.

The program has scheduled group counseling for residential youth/clients five (5) days a week and also provides individual and/or family counseling.

The reviewer inspected four (4) residential youth/client files and four (4) non-residential youth/client files. Each of the files reflected appropriate coordination between presenting problems, psychosocial assessment, service plan (and reviews of progress, as appropriate), case management and any follow-ups due. There were chronological (e.g. daily) notes in each of the residential files pertaining to behavior within the shelter consistent with the behavior management aspect of this indicator. However, chronological case notes for counseling services provided to youth/clients and their families appeared to be stored in a computer instead of in the individuals' files. The reviewer was provided with print outs for several counseling sessions where the date of service was earlier than the 'Note Date', which was given as the date of the review (10/22/15). In one instance, for example, the service date is listed as September 23, 2015, yet the Note Date on the Progress Note was the date of this review: 10/22/15. The fact that these were done the day of the review does not create an exception to the program's satisfactory compliance with this indicator. However, it would be a recommendation to more frequently update the counseling chronological progress notes and place them in the youth/client files to ensure that the service plan is responsive to issues or crises that may arise. It was clarified to this reviewer at the end of review conference that there are chronological notes documented by the counselor after each group session on the back of the behavioral management log forms within each youth/client file.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The program is in satisfactory compliance with this indicator with no exceptions noted.

The program has a policy in place which sets forth the criteria for, and required and optional membership of, a case staffing for a CINS/FINS petition and adjudication. Furthermore, there is outlined the notice requirements to staffing members, which includes youth/clients and their parents/guardians.

This reviewer was provided three (3) files for this indicator. All were referred and initialed by a school social worker. Each file showed that the parent/guardian was notified no less than five (5) days prior to the staffing as required by the indicator. Furthermore, appropriate adequate notice was provided to the case staffing membership. In each instance, the school social worker, plus a program representative were in attendance at the staffing. The files reflected certified mailing receipts to the families and documented that a written report would be provided to the family within seven (7) days. Each file reflected that a new or revised case plan was put in place as a result of a case staffing.

Although none of the files reviewed were referred for judicial intervention. The program's policy provides clear and concise guidance on how the program is to assist in the process, including preparation and delivery of a case review summary prior to a court hearing.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The program is in satisfactory compliance with this indicator with no exceptions noted.

The program has a policy in place, which requires that youth/client files be maintained in a neat and orderly manner, and be clearly labeled 'confidential'. This reviewer found that each of the eight (8) files presented were in compliance with the program's policy in this regard, which complies with the standards of this indicator. The files were organized in such a way that the reviewer could optimally locate information adequately. During the tour of the program's facility, the reviewer noted that the youth/client records are properly stored in a secure room or locked in a file cabinet.

Standard 3: Shelter Care

Overview

Rating Narrative

The agency is currently in the beginning stages of planning to move the residential shelter to their Tiger Bay facility. All non-residential counselors have already moved. They are hoping to have the residential side moved within the next year. The program has access to one full-time licensed mental health counselor and one part-time registered intern to respond to youth with mental health issues and to provide consultation and support to direct care staff members. The BEACH House youth shelter serves both CINS/FINS and DCF referral populations in the residential environment. The youth shelter provides residential services twenty-four hours a day, 365 days per year. The youth shelter operates 3 work shifts and is staffed with both male and female staff members on each shift. At the time of the review the shelter had six CINS/FINS youth. The shelter has not had any Staff Secure youth since the last on-site review; however, has served Domestic Violence and Probation Respite youth.

3.01 Shelter Environment

Satisfactory Limited Failed

Rating Narrative

The Disaster Plan was reviewed appears to be in compliance and up-to-date. The Annual Fire Inspection was also reviewed and everything was in compliance, including sprinklers, extinguishers, and alarm system. It was found that Beach House completes a minimum of one fire drill per shift per quarter. Beach House appears to complete at least one mock emergency drill per quarter. Knife-for-live was located in two different locations. Beach House has a current up-to-date food service inspection report from the Department of Health. Refrigerators and freezers were properly stored and maintained the proper temperatures. Menus are posted and signed by a dietician. Beach House has a current DCF Child Care License displayed in the front entrance of the facility. Facility was clean and no exterior debris was observed. All doors were secure at the facility. Evacuation maps were located throughout the facility. No contraband was found in rooms, bathrooms or common areas. All areas of bathroom and shower appeared to be clean. MSDS sheets were reviewed and appeared to be in compliance. All chemicals were maintained in a locked cabinet. The washer and dryer was operational and free of debris in surrounding areas. Grievances were posted on the door if the youth needed them. There were daily activity schedules posted in more than one area.

3.02 Program Orientation

Satisfactory Limited Failed

Rating Narrative

There were five youth files reviewed to ensure orientation procedures were followed. All five files documented an orientation handbook was provided to the youth within 24 hours of intake. All files also documented grievance procedures and disciplinary actions were explained to the youth. A copy of the Emergency/Disaster procedures was provided to the youth. All youth received a list of what is considered contraband. A physical/facility layout was posted throughout the shelter. The alert board appeared to be up-to-date with current alerts. All intake documents were signed by parent/guardians. Daily activities were reviewed and signed by staff.

3.03 Youth Room Assignment

Satisfactory Limited Failed

Rating Narrative

There were five youth files reviewed for youth room assignment procedures. All youth appeared to be classified by their age, gender, history status and exposure to trauma. Youth alerts were documented throughout the files. All alerts that were written in the intake files were on the alert board (color coded by risk factors).

3.04 Log Books

Satisfactory Limited Failed

Rating Narrative

Logbooks were reviewed for the last six months. There were no concerns in the area of safety and security issues being documented. Staff did a great job of documenting medication counts, shift reviews, intakes and potential intakes. There was also detailed documentation on clinical recommendations. Errors observed in the logbooks were crossed out, initialed and dated. Supervisors reviewed the logbooks well within the time frames. All safety issues were documented. Supervision and resident counts were documented without any concerns. All visitation and home visits were documented and highlighted. All walkthroughs were documented and highlighted. There was no evidence of white-out being used in the logbooks.

3.05 Behavior Management Strategies

Satisfactory Limited Failed

Rating Narrative

Behavior management is tied into the basic therapeutic process at Beach House, and is outlined in the Program Manual, as well as, the Client Handbook. The behavioral management system is based on encouraging clients to utilize pro-social means of getting needs met, and coping with challenging and stressful situations. Clients may earn points based on positive behaviors, and the points are used for earning VIP and Super VIP status, which include rewards such as the following:

*Positive social attention/recognition

*Privileges/ability to participate in special activities

*Special snacks for VIP/Super VIP status clients

Clients have input into the behavioral systems as stakeholders, to ensure that the rewards are appropriate to their preferences. Consequences and sanctions are also part of the behavior management process, also hand in hand with therapeutic process. Negative behaviors are outlined and clearly defined in Client Handbook and Program Manual, and explanations are provided for appropriate and inappropriate behavior. Major and minor violations are outlined in writing.

Dress code for clients is outlined clearly.

Behavior management principles are covered in staff training, and this writer was able to review annual performance evaluations in which participation in all behavioral management processes is noted.

3.06 Staffing and Youth Supervision

Satisfactory Limited Failed

Rating Narrative

Beach House has policies in place that meets the staffing requirements. Beach House maintains the minimum staffing ratios required by contract. It was found that at times only one staff works overnight with both male and female youth present. Program staff schedules are posted for staff review. Administrators will call staff in if extra coverage is needed. All surveillance cameras are well positioned and reviewed by administrators. Logbooks were observed and it showed fifteen minute observations of the youth during sleeping hours.

3.07 Special Populations

Satisfactory Limited Failed

Rating Narrative

There was one youth file available for review for Probation Respite requirements. The youth was referred to Beach House by his probation officer. Beach House was able to provide proof that FNYFS was contacted for approval. It was stated in the area of goals that the youth's goals had to be completed by 6/5/15. The youth was discharged on 6/5/15. It was documented in the discharge summary that the probation youth participated in individual and group counseling. After reviewing the file it appears that the probation youth respite was consistent with all CINS/FINS requirements.

There was one youth file reviewed for Domestic Violence requirements. There was a domestic violence request form located in the legal area of the file. There is a JJIS Youth ID# that shows the youth was input into the system. It was noted on the screening and in other areas of the file that youth had a charge of domestic violence. The youth has not been in the shelter long enough to be transitioned to CINS/FINS or Probation Respite status. The initial service plan documented the youth will receive intensive anger management services. It appears that all other DV youth requirements are consistent with CINS/FINS.

The shelter has not had any staff secure youth since the last on-site review.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The SMA agency provides screening, counseling and mental health assessment services. One BEACH House Counselor is a Licensed Mental Health Counselor (LMHC) and one counselor is a part-time registered intern. The shelter has staff members that are trained to screen, assess, and notify all staff members of conditions and risks of all youth admitted to both residential and non-residential CINS/FINS programs. The shelter staff provides risk screening and identification methods to detect youth referred to the program with mental health and health related risks. Specifically, the shelter utilizes a screening form to determine eligibility and various screening methods to determine the presence of risks in the youth past mental health status, as well as their current status. The shelter also screens for the presence for acute health issues and the agency's ability to address these existing health issues. The shelter uses a general alert board and colored dot system to inform all staff members on each shift of the health and mental health status of all youth in residential youth shelter.

The shelter staff also assists in the delivery of medication to all youth admitted to the residential youth shelter. The shelter operates a detailed medication distribution system. Certain staff are designated to distribute medication. The agency has fully implemented the Pyxis Med-Station 4000 Medication Cabinet. All youth medication is stored in the Medication Cabinet. The agency provides medication distribution training to all direct care staff members, as well as, first aid response, CPR, fire safety, emergency drills and exercises, and training on suicide prevention, observation and intervention techniques. Staff members are also required to notify parents/guardians in the event that a resident has a health injury.

4.01 Healthcare Admission Screening

Satisfactory Limited Failed

Rating Narrative

The agency has a policy for Healthcare Admission Screening that addresses the requirements for this indicator. Upon admission to the shelter, Staff use the CINS/FINS Intake Assessment Form to screen youth for medical, mental health, and substance abuse concerns. The agency does not have a nurse on staff so non-health care staff complete the health screening. The shelter also completes a Health History Addendum and Body Chart on each youth. The Health History Addendum includes a Tuberculosis Screening and a Lice Screening.

There were five open youth files reviewed for Healthcare Admission Screening. In all five files the CINS/FINS Intake Assessment Form was completed at admission, as well as, the Health History Addendum and Body Chart. One of the five youth was on medications and they were listed as well as the reasons for the medications. None of the youth had any chronic medical conditions requiring follow-up medical appointments; however, the agency does have procedures in place for referrals and follow-up medical care if needed. Two youth documented having allergies.

4.02 Suicide Prevention

Satisfactory Limited Failed

Rating Narrative

The agency has a Suicide Prevention Policy in place that meets the requirements of the Florida Network. Youth admitted to the shelter are screened for suicide risk using the CINS/FINS Intake Assessment. If the youth receive any "hits" on questions 1 through 6 they must have a suicide risk assessment completed by a qualified professional. Youth are to be placed on constant sight and sound supervision until the assessment is completed. The assessment must be completed no later than 24 hours after the screening. If at any time during the screening or at any time during the youth's stay at the shelter any staff observes or believes a youth presents as an immediate threat to themselves or others, the youth will be placed on one-to-one supervision and staff will immediately call law enforcement for a Baker Act.

The shelter uses two different levels of supervision, with the most intense level being One-to-One Supervision. This level is used for youth while waiting for removal from the shelter by law enforcement or the guardian for the purpose of Baker Act assessment. The second level of supervision used is Constant Sight and Sound Supervision. This level of supervision is for youth who are identified as being at risk of suicide but are not expressing current suicidal thoughts or threats.

There were three youth files reviewed and all three files documented the CINS/FINS Intake Assessment form was completed during the initial intake and screening process. All CINS/FINS Intake Assessment forms were signed by a supervisor. All three files documented an assessment of suicide risk was completed by a Licensed Mental Health Counselor (LMHC) immediately. The LMHC cleared all three youth for admission to the shelter and the intake process resumed. The youth were not placed on constant sight and sound supervision due to the LMHC completing the assessments immediately during the intake process. There was documentation in the log book each time, by the LMHC, stating the assessment was completed and the youth was cleared for intake.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Medications that was last reviewed and updated in October 2015 and included the use of the new Pyxis Med-Station 4000 Medication Cart.

The agency has fully implemented the Pyxis Med-Station 4000 Medication Cabinet. All youth medication is stored in the Medication Cabinet. After the youth's information is entered into the system, a bin within the Cabinet is assigned to the youth. The youth's medication is placed in that bin and once it is closed it can only be opened during assigned medication times or for inventory purposes. Staff using the Medication Cabinet have to enter a password as well as their finger print to gain access. Two staff credentials are required to open the drawer with the controlled medications. Each medication is stored in its own separate bin within the Medication Cabinet so topical medications are always stored separately. All over-the-counter medication is stored in a separate box, in a locked cabinet, in the medication room. There are four Super Users assigned for the Med-Station. Staff that have access to the Cabinet have been delineated in writing and have been trained on its use.

The shelter has a system in place for refrigeration of medication if needed; however, there was no medication that required refrigeration during the time of review.

All non-controlled medications are inventoried by maintaining a perpetual, running balance when the medication is given. All controlled medications are inventoried three times per day, once on each shift, by two staff members. When an inventory is completed the staff will log into the system and choose which medication to inventory. When the medication is chosen the appropriate drawer and bin will pop open, staff must then count the medication and enter the number into the computer system. If it is a controlled medication a second staff member must also enter their initials and finger print to verify the count. If the count is inaccurate alarms within the Medication Cabinet will sound. The inventory must be completed and the amount must be entered into the computer system in order to close the bin the medication is in and close the drawer. If the count is not entered the door on the bin will not close. These inventories are documented in the Medication Cabinet and also documented on the Medication/Controlled Substance Count Sheet in the Narcotic Medication Count Book, in the logbook and on the shift review forms. Sharps are maintained in a drawer in the medication room and are inventoried weekly and when used. Over the counter medications that are accessed regularly are inventoried by maintaining a perpetual inventory, and also weekly.

There were two youth currently in the shelter on medication. The agency still maintains hard copies of all documents relating to the medication process, as well as, enters all information into the Medication Cabinet system. The youths' Medication Distribution Records (MDR) reviewed documented the youth's name, date of birth, any allergies, side effects of the medication, dosage, reason, method of administration, prescribing physician, full signatures of youth and all staff, and date medication was verified and by whom. Each MDR documented when a medication was given, staff and youth initials, and perpetual inventory with running balance. A cover sheet was located for the youth that included a picture of the youth, the youth's date of birth, and date of intake. All MDR's reviewed for both youth documented that all medication was given at prescribed times.

When the youth are released from the shelter the staff complete the Medication Sign In/Out Form, which documents all medications the youth was taking and how much is left of each medication. This form is signed by the staff and guardian upon returning the medication to the youth's guardian. A review of staff training files revealed staff have been trained in the medication administration process.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written procedure to address the medical and mental health alert process for all youth admitted to the youth shelter. The shelter utilizes a large dry erase board located in the Youth Specialists' office and is concealed from plain view. The shelter uses a color coded alert system with each color identifying a different alert. The applicable color coded dots are placed next to the youth's name on the alert board. The colors used are: dark green for a suicide history; dark blue for mental health; orange for substance abuse; yellow with black dot for runaway behaviors; red for medical and allergies; pink for sexual issues; yellow for out of shelter; light green for no razors; and brown for no outings. Medications and allergies are also documented on the dry erase board in the medication room. An additional dry erase board by the door inside the staff work area is used to also document youth on medications and times to be taken. This serves as an additional step to ensure medications are given and at the designated times.

A review of five open youth files was conducted. All applicable alerts were documented in the youth's file and on the alert board in the staff office. All files also had a sticker on the front of the file checked "yes" for alerts. If the youth had any allergies then they were also documented on the front of the file. Alerts are also documented on the Shift Review Forms. These forms were reviewed to indicate staff were provided sufficient information and instructions regarding the youth's medical conditions, allergies and information to allow them to recognize and respond to the need for emergency care and treatment. All alerts were also appropriately documented on the large dry erase board in the Youth Specialists' office. Any dietary alerts were documented on a form hanging on the refrigerator in the kitchen.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy on Episodic/Emergency Care that meets the requirements of this indicator. A review of the Episodic/Emergency Care Log revealed there was one incident documented. Staff reported they began maintaining this log in July 2015. This incident documented in the log was also documented in the program logbook, on the Shift Review form, and reported to the CCC. There was documentation the youth's parent was notified and there was documentation of discharge instructions and follow-up care. A review of incident reports for the last six months revealed there were no other incidents requiring off-site medical treatment.

The shelter has adequate first aid kits, a knife for life, and a pair of wire cutters. The shelter conducts three medical emergency drills each month, one on each shift. The drills cover an array of emergency medical situations to include: sprained ankles, bee stings, falls, cuts, heart attacks, and choking. All staff have current CPR and first aid certifications.