



# **Florida Network of Youth and Family Services Quality Improvement Program Report**

Review of Youth Crisis Center

on 06/22/2015

## 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

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 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 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

Keith Carr, Lead Reviewer FOREFRONT/FNYFS

Kristi Castaneda, Director of Program Support Services, Boys Town of Central Florida

Jennifer Calame, LCSW, Counseling Services Supervisor, Orange County Government



## Quality Improvement Review

Youth Crisis Center - 06/22/2015

Lead Reviewer: Keith Carr

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Raylene Coe, Street Outreach Coordinator, Crosswinds Youth Services

**Persons Interviewed**

- |                                                      |                          |                         |
|------------------------------------------------------|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 4 Case Managers          | 2 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor                 | 2 Clinical Staff         | 3 Program Supervisors   |
| <input type="checkbox"/> DHA or designee             | 1 Food Service Personnel | 11 Other                |
| <input type="checkbox"/> DMHA or designee            | 0 Health Care Staff      |                         |

**Documents Reviewed**

- |                                                                       |                                                                      |                                                                |
|-----------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------|
| <input checked="" type="checkbox"/> Accreditation Reports             | <input checked="" type="checkbox"/> Fire Prevention Plan             | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records        | <input checked="" type="checkbox"/> Visitation Logs            |
| <input checked="" type="checkbox"/> CCC Reports                       | <input checked="" type="checkbox"/> Key Control Log                  | <input checked="" type="checkbox"/> Youth Handbook             |
| <input type="checkbox"/> Confinement Reports                          | <input checked="" type="checkbox"/> Logbooks                         | 6 Health Records                                               |
| <input checked="" type="checkbox"/> Continuity of Operation Plan      | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 12 MH/SA Records                                               |
| <input type="checkbox"/> Contract Monitoring Reports                  | <input type="checkbox"/> PAR Reports                                 | 32 Personnel Records                                           |
| <input checked="" type="checkbox"/> Contract Scope of Services        | <input checked="" type="checkbox"/> Precautionary Observation Logs   | 23 Training Records/CORE                                       |
| <input checked="" type="checkbox"/> Egress Plans                      | <input checked="" type="checkbox"/> Program Schedules                | 17 Youth Records (Closed)                                      |
| <input type="checkbox"/> Escape Notification/Logs                     | <input type="checkbox"/> Sick Call Logs                              | 19 Youth Records (Open)                                        |
| <input 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 checked="" type="checkbox"/> Telephone Logs                   |                                                                |

**Surveys**

- 13 Youth                      13 Direct Care Staff                      13 Other

**Observations During Review**

- |                                                               |                                                                   |                                                                      |
|---------------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Admissions                | <input checked="" type="checkbox"/> Posting of Abuse Hotline      | <input checked="" type="checkbox"/> Staff Supervision of Youth       |
| <input type="checkbox"/> Confinement                          | <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 checked="" type="checkbox"/> Searches                      | <input type="checkbox"/> Transition/Exit Conferences                 |
| <input checked="" type="checkbox"/> Group                     | <input checked="" type="checkbox"/> Security Video Tapes          | <input type="checkbox"/> Treatment Team Meetings                     |
| <input checked="" type="checkbox"/> Meals                     | <input type="checkbox"/> Sick Call                                | <input type="checkbox"/> Use of Mechanical Restraints                |
| <input type="checkbox"/> Medical Clinic                       | <input type="checkbox"/> Social Skill Modeling by Staff           | <input checked="" type="checkbox"/> Youth Movement and Counts        |
| <input checked="" type="checkbox"/> Medication Administration | <input checked="" type="checkbox"/> Staff Interactions with Youth |                                                                      |

**Comments**

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

Rating Narrative

The agency did not have any Special Populations sample for this onsite program review for Staff Secure Placement and Probation Respite Referrals.

## **Strengths and Innovative Approaches**

### Rating Narrative

The agency is under new leadership and has a recently appointed Kim Sirdevan as its new CEO/President.

The agency has moved to a new residential group care location. This new location is a large modern residential group care facility with a well designed layout for residents and staff offering many options including resident sleeping rooms, common areas, classrooms, cafeteria, administrative and meeting space.

Implementation of new technology with use of the Care Fusion Pyxis Medstation 4000 automated medication distribution system on a daily basis since early April 2015.

The agency is currently revising and updating to a new BMS system and has organized a committee of key staff to implement the new system. The first committee meeting was 02/25/2015 and they expect it to take 4-6 months to get it up and running.

## Standard 1: Management Accountability

### Overview

#### Narrative

The program Youth Crisis Center operates a 30-bed residential shelter and non-residential CINS/FINS program. The program has fifty-eight (58) employees. To evaluate this standard a total of 32 employee files and 2 volunteer files were reviewed, along with the 13 incident reports accepted by DJJ since the last review in May 2014. In addition, the program's Quality Improvements and management data reports were reviewed and the program provided a copy of its Technology Plan (Standard 1.06).

### 1.01 Background Screening

Satisfactory

Limited

Failed

#### Rating Narrative

The program provided a copy of its Annual Affidavit of Compliance with Good Moral Character Standards that was sent to DJJ on January 20, 2015.

The program has an established background screening policy (1.07) that requires screening prior to employment as well as follow-up rescreening every five years. The program maintains records pertaining to these background screenings in each individual employee's file. This reviewer found that these files were kept in an organized and secure manner and were neat and orderly.

There have been 11 new staff members added to the program since the last Florida Network review in May 2014. All 11 employee files contained evidence of background screenings having been performed prior to each employees' respective start date.

All employees are also supposed to be rescreened every five (5) years. This reviewer looked at 100% of the program's employee files subject to this requirement: meaning they were hired/started working at the program five or more years ago. A total of 21 employee files and 2 volunteer files were subject to this requirement. However, two (2) of those employee files were still within the rescreen time frame as they were hired in July and August of 2010 respectively (one of these has already been rescreened).

Of the 21 employee files reviewed, all reflected timely pre-service background screening and follow-up rescreens were done within 12 months of their respective due date(s) in all, but two of the files reviewed. One long time employee had late rescreens in 2001 and 2006; while another employee was prematurely rescreened two years prior to her due date, but not rescreened within 12 months of the due date. Overall, these incidents reflect an oversight or misunderstanding of the requirement.

### 1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

#### Rating Narrative

The program has established "Workplace Policies", found in section "C" of the Employee Handbook, that outlines "rules of conduct that will protect the interest and safety of all employees and the organization." Further, the program has an established "Abuse Free Environment" policy (1.09) to ensure that youth and staff feel safe and free from abuse, harm or harassment. This policy not only defines what constitutes abuse, neglect or threatened harm, but also establishes systemic procedures all staff must follow in reporting known or suspected abuse or neglect.

This reviewer noted that the program has subliminal messages around entrance ways to help instill values of tolerance, integrity and accountability in the youth served. The program also has anti-bullying posters through-out its dormitories and common areas.

The program requires each newly hired employee to acknowledge their mandatory obligation to report known or suspected abuse of a child and, as required by sec. 415.1034, F.S., a vulnerable adult. All thirty-two (32) files reviewed contained these acknowledgement forms signed by each employee, as well as the employees' acknowledgement of the program's guidelines to prevent abuse. All program new-hires acknowledge their responsibility to complete a review of the program's operations manual, which describes the policies and procedures and other important program information, and all staff acknowledge on a separate form that they will be responsible for complying with the contents of the program's operations manual.

The program provided this reviewer with a copy of its employee handbook. Each employee is required to comply with the code of conduct outlined in the handbook as set forth in the policy (1.09). This code of conduct prohibits the use of physical abuse, profanity, threats, intimidation and requires respect, cultural sensativity, courteousness and non-aggressive behavior at all times.

There were thirteen (13) youth surveys taken and the responses were for the majority very positive toward staff and the practices of the shelter. All youth reported they knew about the abuse hotline and where it was posted in the shelter. None of the youth have ever heard staff use profanity or threats toward youth. Twelve youth reported feeling safe in the shelter. They all knew how to use the grievance process. Ten youth rated the provider very good and two rated them good.

No exceptions are noted.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

#### Rating Narrative

The program has policies in place (1.09 and 1.11) that require reporting of incidents that occur with youth in the program. Per those policies, the program requires that the Central Communications Center (CCC) be notified within 2 hours of the occurrence of an incident or within two hours of staff learning of an accident or incident. This is a requirement established by the DJJ. DJJ's CCC provided reports for thirteen (13) incidents that it accepted from the program since the last Florida Network review in May 2014.

Of the 13 DJJ CCC accepted incident reports reviewed, all but three (3) appear to have been reported to the CCC within the 2-hour window.

One incident was acknowledged by staff at 11 pm, but not was not reported to the CCC until the following evening. The other two incidents occurred in similar circumstances where the youth absconded at the same time of day (7:00 pm), but the report to the CCC was made outside the 2 hour window. A review of the program's internal incident reports substantiate these delayed CCC notifications.

### 1.04 Training Requirements

Satisfactory

Limited

Failed

#### Rating Narrative

The program has an established policy (1.05) pertaining to Staff Training, which requires 80 hours of training in the first year of employment and at least 24 hours of job-related training annually thereafter for all direct care staff.

The program provided this reviewer with its Training Plan, which establishes which employees are direct care employees, who upon hiring must complete at least 80 hours of training that includes the required and recommended subject matter courses listed: Orientation, Child Abuse Reporting Procedures, Responses to Emergency Situations, Sexual Harassment for Employees, Safe Place, Training Requirements and Documentation, CPR, First Aid, Crisis Intervention, Walk Through, Confidentiality, Fire Safety, Incident Reports, Behavior Management, Title IV-E, Signs and Symptoms of Mental Health and Substance Abuse, Individual and Group Interactions, Self Defense (CPI), Crisis Calls, Risk Factors, Netmis, CINS Core (I, II, and III), Brief FAM, Residential Intakes, Crisis Intervention and Risk Assessment, Proactive Intervention, Bloodborn Pathogens, Cultural Diversity, Permanent Releases/Absconsions, Professional Boundaries and Ethics, Red Flag Behaviors, Suicide Prevention, Trauma Informed Care, Youth Supervision and Report Writing, Quality Assurance, and Customer Service.

In addition, the program's Training Plan requires annual training after the first year of employment in specific topics to include: Sexual Harassment, Fire Safety, CPR and First Aid, Crisis Intervention and Risk Assessment, Proactive Intervention, Bloodborn Pathogens, Responses to Emergency Situations, Suicide Prevention, Trauma Informed Care, CPI (refresher), and Quality Assurance. The plan also incorporates that staff who change positions into a direct care role must complete any additional training year requirements. There are abbreviated training requirements for those in non-direct care positions that conform to the minimum training requirements for Florida Network providers.

The program provides a training calendar in its Training Plan. It appears that each employee is responsible for ensuring that they have taken their required trainings.

The program maintains individual training files on each employee. The files were neat and organized. After the first year, reporting of accumulated training hours is compiled by fiscal year (July 1 through June 30) as opposed to the amount of training hours each employee has accrued from their last hire date anniversary.

The program provided the training files of 11 employees who were hired since the last Florida Network Review in May 2014. However, only one of these employees had completed a full year of employment at the program. This employee's file reflected documentation by way of certificates or cards that she had completed the required and recommended trainings, including specifically, Cultural Competency, and had accumulated 93.5 hours of training through-out the year, which included 13.5 hours of Orientation on a single date. This reviewer noted to the program's HR representative that all 11 of the new hire files reflected single work day Orientation training in excess of 12 hours.

The program is consistently utilizing the Blood-born Pathogens course to meet the requirement for training in Universal Precautions. After reviewing the outline, it was determined to be an acceptable alternative. All employee files reviewed contained certificates of completion for Prison Rape Elimination Act (PREA) training. However, there were various suicide-related trainings being taken by staff. For example, one employee took Suicide Assessment and Intervention as well as Suicide (Part C) Manipulative Threats. It is recommended that annual Suicide

Prevention training be standardized to a specifically titled training to eliminate confusion. There was also some discrepancy with regard to the required annual Cultural Competency training, which has as its focus the wider scope of youth and their families, as well as fellow staff members. Six of the 11 new hires, who are still in their first year of employment, had completed the Embracing Diversity In The Work Place training, but not the Cultural Competency. The program provided a printout of the Diversity in the Workplace course and feels it is similar enough to the Cultural Competency to meet the training requirement.

This reviewer looked at 8 established employees' files and 2 volunteer files. The program's HR representative provides a list of completed trainings within each employees' file based on the fiscal year (not from respective employees' hire date) and all but one of the employees had acquired in excess of 24 hours of training. This employee actually has until July to meet the required number of training hours. Notably, all but 2 of the 8 employees had training in excess of the required 40 hrs.

Although the Cultural Competency course is available, only 4 of the 19 staff files reflected that they had actually taken that specific course (11 had instead taken the Embracing Diversity course). As mentioned previously, it is not clear that this is an accepted alternative to meet the requirement. With this qualification, it appears that the program is meeting its training requirements for both new hires and annual follow-ups.

### 1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

#### Rating Narrative

The program has an established Quality Improvement process that allows management to compile information for analysis of trends and outcomes. A review of the compiled Quality Improvement documentation reveals that each area (a/k/a Department) within the program compiles and provides a summary data report of their status to the management team. These various reports include case record reviews, reviews of incidents, accidents and grievances, customer satisfaction data, outcome data, and monthly review of NetMIS data reports.

The program recently engaged in continuous monitoring of the data being entered into NetMIS, which is reported to the management team monthly and alerts the staff to data entry error trends weekly for immediate remedial training. For example, according to Susan Spinella, VP of Quality Assurance, the program's 30 and 60 day follow-ups were revealed as being done too early by this monitoring process. The program was able to implement remedial training and recover its schedule to ensure proper credit for the follow-ups.

The program provided reports of aggregated data and meeting minutes compiled into a QIC notebook. When there are improvements or changes needed, there is evidence of corrective action being taken in the form of retraining or modification of processes.

The program has recently engaged in data entry into the Homeless Management Information System (HMIS) and plans to incorporate that data into its operational analysis.

## Standard 2: Intervention and Case Management

### Overview

#### Rating Narrative

The Youth Crisis Center operates residential and non-residential services to provide CINS/FINS services. The youth shelter has 3 therapists under the supervision of the Vice President of Clinical Services. The Family Link program has 5 therapists and 2 case managers under the supervision of the Vice President of Clinical Services. Currently they also have an intern.

The review process included a facility tour and review of operational manual as well as communication with the Vice President of Quality Assurance and Vice President of Clinical Services. There was also an opportunity to talk with all case managers. There were 12 files that were reviewed on site: 5 residential files, 4 non-residential, and 3 for the purpose of the adjudication process (case staffing committee).

### 2.01 Screening and Intake

Satisfactory                       Limited                       Failed

#### Rating Narrative

The YCC has policies in place for screening and intake. A total of Five (5) residential files were reviewed: 3 open and 2 closed. For the purposes of determining the agency's adherence to the requirements of this indicator a total of four (4) non-residential files were reviewed: 2 open and 2 closed.

The Consent to Services provides information about available service options, rights and responsibilities, and grievance procedures in residential and non-residential files. The consent also includes acknowledgement that a brochure about services was received. In residential files, the Placement Agreement documents receipt of the Parent/Guardian brochure which informs about possible actions through CINS/FINS services.

There is a Client Orientation form that sets expectations for youth such as: When you leave, the facility must be in the same condition as it was before you came. When you leave, you must be in the same condition as you were before you came. Then a positive message is delivered to the youth through the form: The only thing we want you to change during your time at YCC is your future.

No exceptions noted for the indicator.

### 2.02 Needs Assessment

Satisfactory                       Limited                       Failed

#### Rating Narrative

The YCC has a policy for the psychosocial assessment. For the purposes of determining the agency's adherence to the requirements of this indicator a total of Five (5) residential files were reviewed (3 open and 2 closed) and a total of four (4) non-residential files were reviewed (2 open and 2 closed).

All assessments were completed within timeframes by an appropriate level staff and signed by a supervisor. An elevated risk of suicide was identified in 2 residential and 2 non-residential cases. All 4 cases had further evaluation under the direct supervision of the vice president of clinical services.

No exceptions are noted.

### 2.03 Case/Service Plan

Satisfactory                       Limited                       Failed

#### Rating Narrative

The YCC has policies in place for service planning. For the purposes of determining the agency's adherence to the requirements of this indicator a total of Five (5) residential files were reviewed (3 open and 2 closed) and a total of four (4) non-residential files were reviewed (2 open and 2 closed).

The service plan template contains all elements required by Florida Network. All plans were developed within the required timeframe. The non-residential service plans were reviewed every 30 days for progress with the youth.

Exceptions are noted for this indicator.

Residential: The service plans in the closed files had parent/guardian signature. The service plans for the open residential files did not have parent/guardian signature. A.B. had documentation that the service plan was reviewed with parent by phone. K.D. and C.A. had notation that effort would be made to contact the parent.

Service plan reviews on the open files are not due yet. The plan for D.H. (closed) was reviewed while a code was not noted. I.T. (closed) did not have a 30 day review. D.H. and I.T. did not have an actual completion date noted. Two additional closed files were reviewed specifically for the service plan - C.B. and J.C. each had the completion date marked and dated.

Non-residential: There were two services plans that were not signed by the parent (K.B. and L.F.). It was noted that the plan was reviewed with the parent by phone.

## 2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

### Rating Narrative

There are policies in place for case management and service delivery. For the purposes of determining the agency's adherence to the requirements of this indicator a total of Five (5) residential files were reviewed (3 open and 2 closed) and a total of four (4) non-residential files were reviewed (2 open and 2 closed).

The file documentation that supports service delivery included the service plan, progress notes, and a standard form to mark recommended referrals. A positive intervention was clearly documented throughout progress notes in a non-residential file (N.Mc) which described improved moods, decreased symptoms, and involvement in extracurricular activity.

No exceptions are documented for this indicator.

## 2.05 Counseling Services

Satisfactory

Limited

Failed

### Rating Narrative

YCC has policies in place regarding counseling services. For the purposes of determining the agency's adherence to the requirements of this indicator a total of Five (5) residential files were reviewed (3 open and 2 closed) and a total of four (4) non-residential files were reviewed (2 open and 2 closed).

The file documentation supports provision of counseling services included psychosocial assessment, service planning, and progress notes. A case review form was located in 2 non-residential files to document an internal process for clinical review. A treatment team form was located in 2 closed residential files to document an internal process for clinical review.

There are exceptions noted for this indicator.

The open residential files did not contain clear documentation about an ongoing internal process for clinical reviews. The Quality Assurance VP indicated that the clinical reviews are documented by the review of the needs assessment and service plan. The 2 closed files had a treatment team review form with supervisor signature.

Two (2) of the 4 non-residential files had the case review form.

## 2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

### Rating Narrative

The YCC has policies in place for case management procedure that include when to move toward the adjudication process (case management staffing) along with policy for the case management staffing.

Three (3) files were reviewed that had been through the Case Staffing process. A local school district representative was present at each staffing along with DJJ and a CINS/FINS provider. Other participants were present as appropriate. If a family did not attend the staffing, a letter

with the recommendations was sent within the timeframe. If the family attended, the program stated that a copy of the recommendation form was given to the family.

Exceptions are noted for this indicator. Three (3) files were reviewed that had been through the Case Staffing process. Two (2) of 3 had documentation of a new or revised plan as a result of the case staffing. One (M.S.) did not have documentation of a new or revised plan after case staffings (10/21/14, 11/18/14, 12/2/14). The case plan in the file is dated 10/8/14. M.S. file contains partial documentation for the PDS and Judicial Review Summary.

## 2.07 Youth Records

Satisfactory

Limited

Failed

### Rating Narrative

YCC has policy in place regarding Youth Records. Open residential client files were observed in binders. The covers have a sheet that identify confidential and privileged information. Three (3) closed residential files were observed with confidential and privileged information stamp on the front cover. The 7 non-residential files were observed with confidential and privileged information stamp on the front cover.

Open residential files are stored in a cabinet in a secure room near the staff desk area. During the tour, a staff was observed reviewing the files. Open non-residential files are stored based on counselor location: locked rolling bag or locked cabinet in office or off site location (such as school).

No exceptions are noted for this indicator.

## Standard 3: Shelter Care

### Overview

#### Rating Narrative

The Youth Crisis Center is a safe place for children. The shelter moved from their old shelter into what was the group home in August 2014. The shelter has 30 beds and is equipped with all necessary safety practices and equipment. The shelter is well staffed and is always in the proper ratio of staff to youth. The youth have a male side and a female side with two levels on each side. Level I has three rooms with two beds in each room and Level II has nine rooms with one bed in each room. The building is very large and has two school rooms, library, common areas, cafeteria and an intake room. The youth reported feeling safe here and had good comments about interacting with the staff. The youth work on a point system of 0-4 points daily. Zero is like an "F" and a 4 is like an "A". They earn points when they participate positively in activities. These points are kept daily on a tracking sheet and the overnight staff total up the points for the youth for the next day. All activity in the shelter is documented in the logbook. There is a color code and contact code staff using when documenting activities, drills, risks, incident reporting and special needs. There are daily activity calendars posted in the shelter and they include social, educational, spiritual and recreational activities. The youth dorm rooms were neat and clean with minimal graffiti observed. Youth surveys were positive toward staff and program. Staff surveys showed they knew all safety practices and felt communication in the shelter was good.

### 3.01 Shelter Environment

Satisfactory

Limited

Failed

#### Rating Narrative

There is a policy in place for the emergency disaster preparedness plan and fire prevention. The emergency disaster plan is updated annually and has twenty three different emergency procedures along with evacuations sites, directions, response teams, universal agreement and important resources. Evacuation plans were detailed and observed throughout the shelter and administrative office area.

Fire drills, emergency preparedness drills and first aid drills were reviewed from November 2014 to May 2015. The agency completes one fire drill per month and all were under two minutes long. The agency completes a minimum of one mock emergency drill per shift every quarter. The facility has stocked first aid kits (2), wire cutters, knife for life and bloodborne pathogen kit.

Annual fire inspections, fire extinguishers, range hood inspections and health inspections were reviewed. Four vans were observed having all essential safety requirements. First Aid checks are done monthly and were observed from November 2014 to May 2015. Insurance and registration were in a binder in each van. Several cars in the parking lot were checked and all but one had all the doors locked, this vehicle could have been a visitor.

The kitchen is spacious and clean in the eating area as well as the cooking area. Thermometers were observed in all refrigerators and freezers and the dry storage area was well maintained and had all food up off the ground. Appliances are well kept and clean. A menu was posted and a licensed dietician has signed off from May 2015 to July 2015.

The shelter has a 16 HD camera surveillance system. There is a policy around the cameras as well. The shelter is very clean with two sides a male side and female side. They have two levels in each side, level one has three bedrooms with two beds in each, level two has nine rooms with one bed in each. The rooms were clean and neat. Grievance forms were in common areas for youth to use as they needed. There was one grievance in the last six months that was submitted on 4/16 and had a supervisor sign off on 4/17. This grievance warranted a CCC call but was not accepted. Florida Abuse Hotline posters were posted through the shelter in English and Spanish. The shelter has a very large laundry room where staff does laundry on the overnight shift. The shelter has an intake room, visitation room/library and also two classrooms. Chemical inventories are being completed monthly and the chemicals storage room was well organized. The shelter completes weekly health and safety inspections. The grounds are kept up nicely. There are signs posted for "No Alcohol or Drug Use Prohibited" and there is a "Smoke Free Environment" sign at the entrance.

There were thirteen youth surveys taken and the responses were for the majority very positive toward staff and the practices of the shelter. All youth reported they knew about the abuse hotline and where it was posted in the shelter. None of the youth have ever heard staff use profanity or threats toward youth. Twelve youth reported feeling safe in the shelter. They all knew how to use the grievance process. Ten youth rated the provider very good and two rated them good.

There were six staff surveys completed. Four staff reported working conditions were very good, one reported good and one reported fair. All the staff were aware of the process for the abuse hotline and CCC reporting. One staff reported they observed another co-worker using profanity when speaking to a youth. One staff reported they observed a co-worker using threats, intimidation, or humiliation when interacting with a youth. Staff reported they knew their responsibilities if a youth expresses suicidal thoughts. Three of the six staff reported knowing that the Suicide Response Kit was kept in the wall mounted metal box behind the staff station desk. All staff were aware of the medical/mental health alert system and four staff felt the communication of this system was very good, one thought it was good and one thought it was fair.

Initial tour revealed minor graffiti seen on bed frames, dressers and walls (girls level I rooms 1-3 and boys level I rooms 1 & 2). There was also some graffiti seen in one of the boys rooms in level II, but the Residential Director removed it at the time it was found. There was some dust/mold seen on vents in the boys level I rooms and the facilities manager was shown and said it would be cleaned. This was also cleaned on

day 1 of the onsite program review. There was a white carpet stain in room B209. In one of the boys bathrooms there was a missing cover for the shower handle. This cover was repaired and installed professionally by day 2 of the onsite program review.

Other observations of safety concerns are the propane tanks being accessible to youth and are not locked up/away. There was a thick black rope that was half buried with a loop on the end next to the sidewalk. This may be a hazard for youth, visitors or staff walking by and tripping in the loop of the rope. Update on 5/28/15, the Residential Director had the black tree ropes cut and was working with maintenance staff on locking up the propane tanks.

### 3.02 Program Orientation

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy in place for Program Orientation. This reviewer conducted a review of four (4) residential files, two open and two closed. All the files had all the required components for orientation with 24 hours of admission. The agency uses a checklist list that is signed by both clients and staff members. The agency also has a client orientation handbook that goes over their mission and program goals, linens/bedding, clothing, letter and postage policy and their behavior management system in detail. All the other requirements are included on the checklist.

No exceptions are documented for this indicator.

### 3.03 Youth Room Assignment

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy for Youth Room Assignment. This reviewer assessed four (4) residential files, two (2) open and 2 closed. The agency uses the Youth Crisis Center Admission Form to look for age, gender, history of violence or suicide, physical size/strength and any potential alerts. On the back page is the room assignment form. The section with "history's" on all four files had nothing marked. Three of the four files had no room number assigned (A.B., J.C., C.B.). One file needs a supervisor signature on the Admission Form (A.B.).

Exceptions are noted for this indicator. Three of the four files had no room number assigned (A.B., J.C., C.B.). One file needs a supervisor signature on the Admission Form (A.B.).

### 3.04 Log Books

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy in place for Logbooks. This reviewer conducted a full review of the logbook from November 2014 to May 2015. The logbook has the policy on the first two pages when you open the book. The agency uses a contact for the second column and a narrative explanation in the third column. There is a color code: Orange is for drills, weather alerts, weekly safety inspections; Green is for risk and staff secure risk (more for one on one supervision); Yellow is for incident reports; Pink is for special needs.

Supervisors and the Residential Director are doing their reviews weekly. The supervisors are giving the most feedback in their reviews. For the most part all other direct care staff except for those mentioned in the exceptions are reviewing the logbook at sign in.

The logbook had detailed entries of the activities in the shelter and were for the most part consistent with the color coding system and the contact codes usage.

There are exceptions documented for this indicator.

Two staff on the overnight shift consistently did not document that they reviewed previous logbook notes (B.D. and S. H.).

Two entries around verifying youth's medications or a youth being on medication were not highlighted pink. (11/6 and 2/14)

The following dates have incorrect "voids", 2/19, 3/4, 3/6, 3/21 (2), 3/28, 3/29, 4/6 and 4/26.

There are several entries about absconding youth that were not highlighted in yellow for an incident report but then I saw others that were. The ones I saw that were not highlighted were on dates 2/21 and 2/23.

The Residential Director is using "O" for the contact code instead of "PM" which is in the policy.

### 3.05 Behavior Management Strategies

Satisfactory  Limited  Failed

#### Rating Narrative

The agency has a policy for Behavior Management Strategies and one for Behavioral Interventions. The policy outlines that their behavior management system is a point system. Youth can earn from 0-4 points per day with the capability of earning 100 points per day and 700 per week. Youth earn points for activities or events that they are expected to participate in daily. The policy gives examples of what earning a zero would include as well as a 3 and 4. The BMS system is designed to promote positive behavior and compliance to rules. Consequences are individual and examples are given. Consequences are logical and are designed to promote skill building. The client handbook also has the behavioral management system listed in detail.

This reviewer conducted an assessment of five (5) random staff member files and all staff had the training in their first year but one staff member has not, but his hire date was in June 25, 2014 so he has one month to complete it.

This reviewer assessed a total of four (4) youth active files and verified BMS sheets in all the files and that they were up to date. In most cases, for each day the youth scored 4's for all activities. This reviewer did confirm a few 3's and three zero's on one day for one youth. Some youth were observed in school competing in a team building activity and they all were compliant with the rules and were having fun with staff and the teacher. Other youth were observed watching a movie with staff and were also compliant.

There are daily observations of staff by supervisors and feedback is given.

The agency is currently revising and updating to a new BMS system and has organized a committee of key staff to implement the new system. The first committee meeting was 02/25/2015 and they expect it to take 4-6 months to get it up and running.

No exceptions are noted for this indicator.

### 3.06 Staffing and Youth Supervision

Satisfactory  Limited  Failed

#### Rating Narrative

The agency has a policy on Staffing & Youth Supervision. The policy states that they comply with the F.A.C. and contract of 1 staff to 6 youth during awake hours and 1 staff to 12 youth during sleeping hours. I reviewed the staff schedule and the relief staff schedule along with the logbook and their schedules showed they meet the criteria for each shift and had at least one staff that was male and one that was female for each shift each day as well. The overnight staff always had a minimum of three staff on for that shift.

The agency has an HD camera surveillance system, sixteen cameras, the system holds a months worth of recording. I reviewed both the girl's and boy's overnight logbook and saw that staff are completing fifteen minute bed checks every night. Staff schedules are posted and there is a list of relief staff as well.

There are no exceptions noted for this indicator.

### 3.07 Special Populations

Satisfactory  Limited  Failed

Rating Narrative

There is a policy in place around Staff Secure and Special Populations. A total of four (4) Domestic Violence files were reviewed. The agency has assigned bed days approved by the Florida Network so no prior authorizations were required. All files had a "face sheet" completed by DJJ with the charge of battery evident. Two of the four files had a new NETMIS Intake sheet that showed the transition from DV to CINS. One file we could not find the CINS NETMIS Intake sheet. The fourth file's admission date was 5/14/15 and he is at his 14 day limit today(R.K.). All case plans reflected goals around referral behaviors such as anger control, impulse control, coping skills and showing respect. All files showed the services provided are consistent with all general CINS/FINS program requirements.

Exceptions are documented for this indicator by the reviewer. Two of the four files had a new NETMIS Intake sheet that showed the transition from DV to CINS. A CINS NETMIS Intake form was not located in one client file. The fourth file's admission date was 05/14/2015 and this client is at the maximum of day 14 today on day 2 of the onsite program review. At the time that this reviewer gained knowledge of this resident's status the agency had not activity documented on the client's plan.

## Standard 4: Mental Health/Health Services

### Overview

#### Rating Narrative

The agency provides risk screening and identification methods to detect youth referred to their programs with mental health and health related risks. Specifically, the agency utilizes screening and a Health Screening and other assessment forms 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 agency also screens for the presence for acute health issues and the agency's ability to address these existing health issues. The residential program uses a general alert board to inform all staff members on each shift of the health and mental health status of all youth in youth shelter.

The agency provides assistance to all youth admitted to the program that require medication. The agency provides medication distribution training to select direct care staff members. The agency does provide all staff with first aid response, CPR, first aid, fire safety, emergency drills and exercises and training on suicide prevention, observation and intervention techniques. At the time of this onsite Quality Improvement program review, the agency has an active and functional suicide risk screening process. In addition, the agency has a LMHC Clinical Supervisor and master level counselors that are the key members conduct the assessment phase of the suicide assessment process.

### 4.01 Healthcare Admission Screening

Satisfactory
  Limited
  Failed

#### Rating Narrative

The agency/local service provider has a written policy that addresses the agency's protocol and admission processing to include an in-depth health screening through the completion of the YCC Youth Crisis Center (YCC) Admission Form. The Physical and Mental Health Screening form is located on page 2 of 4 and addresses a broad range of health and medical related screening elements that include any observable injury, illness or health related issues including physical distress or mobility difficulties. The Physical and Mental Health Screening Form screens form acute or chronic medical, dental or mental health condition/concerns. The form also screens for any recent injuries or illnesses that require current medical care. The form screens for current pain or physical distress that requires medical care. The form screens for any food, medication or general allergies and any dietary restrictions, nutritional concerns or fitness issues. The form screens for current physical limitation prevention client from participation in the resident program. The form also asks for the following conditions that include asthma, recent bleeding disorder (past 2 weeks), heart condition, diabetes, head injury, seizures/blackouts, tuberculosis, pregnancy+, hepatitis or other.

The procedures indicate that the agency provides full access to emergency medical care at all times. Further, the procedures indicate that if the screening results indicate a client that has a health or medical health condition it requires that the agency to execute a medical referral to address the issue.

All medical or mental health issues that arise during a shelter stay are provide with the appropriate medical or mental health response and will be referred directly to their physician, emergency room. The policy indicates that staff members would contact the parent/legal guardian to obtain information about pending appointments with medical professionals, current medications and general precautions in the case of an emergency.

A total of six (6) files (four open and two closed files) reviewed contained documentation on the YCC Youth Crisis Center (YCC) Admission Form that was completed the day of the youth's admission. The form addressed all elements of the indicator including observation of scars, tattoos, bruises or other skin markings. All 6 files reviewed contained evidence that all sections were completed as required. None of the cases reviewed required the staff to perform a referral and or ensure follow-up medical care on a issue resulting from the Health Care Admission Screening Process.

No exceptions noted for the Healthcare Admission Screening indicator.

### 4.02 Suicide Prevention

Satisfactory
  Limited
  Failed

#### Rating Narrative

The agency has detailed policies and procedures for screening and assessing youth that are identified as having risks for suicide prevention.

The plan indicated each youth admitted to the shelter is required to be screened for suicidal risk through the use of the six (6) suicide risk questions on the CINS/FINS Intake form. If the youth answers "yes" to any of the 6 questions, the youth care worker will immediately refer the youth to a qualified mental health professional to determine the specific level of suicide risk or, if a qualified mental health professional is not available the youth is to placed on Constant Sight and Sound supervision until a full suicide assessment can be completed by a qualified and trained mental health professional. The shelter utilizes two (2) levels of supervision: one to one supervision and constant sight and sound supervision. The plan addresses all elements of the indicator and complies with the procedures outlined in the Florida Network's Policy and

Procedure Manual for CINS/FINS.

A total of five (5) client files were used in the assessment of this indicator. All 5 files reviewed (two open files and three closed files) contained documentation that indicated a suicide risk screening was completed during the initial intake and screening process. The suicide risk was identified during the initial screening process in 4 cases; the suicide risk was identified during assessment for 1 case. All youth appeared to be placed on an appropriate level of supervision. The YCC admission form has the risk screening questions with distinction as to whether youth should be placed on one-to-one supervision or sight and sound supervision. The section also contains notes with instructions for staff.

All 5 files contained documentation that indicated the suicide screening results were reviewed and signed by the supervisor who was also the licensed clinical social worker. Four (4) out of 5 youth were placed on sight and sound supervision until assessed by a licensed professional or non-licensed staff under the direct supervision of the licensed professional. The supervision level was not changed or reduced until approved by a licensed professional. Two (2) of the 3 files were applicable for sight and sound supervision requirements. All 5 youth were placed on the appropriate level of supervision based on the suicide risk assessment results. Supportive documentation was documented in all 5 cases related to the agency conducting precautionary observation checks as required.

There are exceptions that are documented for this indicator.

One client file was on sight and sound OR one-one supervision from 05/12/2015 through 05/18/2015. A total of 1 of 9 observation logs related to the aforementioned file is missing a date and supervisory signature.

A resident that was identified at intake 02/06/2015. A risk assessment was completed 02/07/2015 recommending sight and sound and re-assessment in 24 hours. The re-assessment (follow up reassessment) was not located in the file. Youth was placed on observation and observation logs were in the file from 02/06/2015 through 02/09/2015. There is a residential progress note dated 02/08/2015 that youth was taken off sight and sound. The discontinuation of precautions documentation was not located in the file.

#### 4.03 Medications

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has a recent medication policy that was last updated in November 2014. The current policy includes focus areas that include Medication Storage, Access to Medication, Medication/Sharps Inventory, Non-Controlled Prescribed Medications, Over-the-Counter Medication, Prescribed Medication, Medication Disposal, Medication Supervision and Monitoring, Medication Distribution Procedure, YCC Over-the-Counter Medication and First Aid/Health Supplies, Prescription/Prescribed Medication, Distributing Medications, Refusal to take Medication, Missed Client's Medication, Medical Resources available to YCC Clients. The agency still utilizes the expertise of the half-time Registered Nurse at a total of 20 hours per work week Monday-Friday. The agency's nurse provided the training and remedial training for all staff. The agency has a list of staff that have been trained by the registered nurse and are authorized to distribute medication.

The agency has launched the use of the CareFusion Pyxis MedStation in early April. Specific staff have been trained on the use of the MedStation and are using the machine on the daily basis to execute medication distribution.

The agency uses a morning, afternoon and evening chart to inform staff what period during the day that certain youth are to be given medication. The shelter has implemented a process where two (2) employees are required to conduct medications counts to ensure accuracy and completion of medication inventory counts of all controlled medication across all 3 work shifts. The monitor assigned to the indicator observed two (2) medication shift counts during the 2 day onsite program and a found this process to be functioning according to its procedures. This monitor also observed the AM or morning medication pass executed by the agency's nurse on day 2 of the onsite program review. The nurse administered and documented medication according to the agency protocol with no issues cited.

The majority of medications are stored in the Pyxis Medstation 4000 following verification of the medication by the local pharmacy. The Medstation is housed in a separate locked room that is dedicated for the sole purpose of medication storage. This room is inaccessible to shelter residents. The Medstation 4000 stores medication in locked drawers. The Medstation can only be accessed by entering a personal identification number and biometric scanning of a finger print. The Medstation contains drawers that include individual locking medication cubes that house each medication prescribed to a specific resident. The agency has separate metal locking wall shelves designated for sharps. The agency had a total of eight (8) scissors (5 large and 3 small) sharps in the shelter. At the time of this review, there were no injectable medications on site. Additionally, there is a locking refrigerator designed for refrigerated medications. There were no medications that required refrigeration on site at the time of this review.

The agency requires that all medication including over the counter medication brought in the shelter by a resident admitted to the program be prescribed by a medical doctor.

The actual medication is stored in the Medstation 400 in its original bottle or box in a separate cube assigned electronically to the client's name and Medstation ID client number. Colored dots are affixed on the bag that corresponds with Red for controlled; Yellow for AM medication; and

Blue for PM medication. These dots provide a color to indicate what time of day the medication is to be given to the resident.

The agency is still required to use the traditional medication documentation process that includes documenting all prescribed medication on a traditional Medication Distribution Record (MDR). A review of seven (7) client medication distribution records were reviewed to determine accuracy and completion of the agency's practice. The MDR reviewed contained records that included evidence of the each resident's name, picture, allergies, and side effects, dosage, dosage instructions, and reason for medications. The medication log contained the youth admission date and time. The agency's controlled medication shift to shift counts were mostly accurate across all 7 resident medication files. The start and stop dates for medications were clearly documented on the medication log. In addition, the medication log clearly documented when a youth is off site for temporary release.

At the time of this onsite QI program review, the agency had no medications that had been left behind after youth had been discharged from the residential program. The agency does utilize a disposal process that is overseen by the nurse and required disposal requires witness documentation of two (2) persons.

The agency utilizes a weekly medication check process to determine sufficient amounts of a resident's medication are on hand. If their medication stock is less than a 7 day supply then the program contacts the parent and or guardian to obtain a refill of the required medication.

The agency Pyxis MedStation is showing Discrepancies during the training period prior to the agency going live that have not been cleared from the system. A total of thirty-five Discrepancies are listed that include inventory and removals. Multiple Discrepancies are listed in the MedStation during the training period. Discrepancies originate from the agency going live with the MedStation as of April 6, 2015.

Exceptions are noted for this indicator. Three (3) Medication Distribution Log (MDL) forms of open residential clients have a blank space on the form that include the "Received From" and "Staff Receiving" areas on the form. One closed file of a youth (I'Yannah Thomas) on prescribed medication is missing staff initials and medication count on at least one shift on three (3) separate dates.

A total of 2 medications errors were documented as Accepted DJJ CCC Incidents within the last 6 months. Of these incidents, one occurred in March 2015 (missed AM med pass) and one in May (missed PM med pass) 2015. Both errors indicate that the resident did not receive their medication as required. Each incident has documented evidence of follow up procedures conducted by the agency to address the root cause of the error.

#### 4.04 Medical/Mental Health Alert Process

Satisfactory                       Limited                       Failed

##### Rating Narrative

The agency has a written procedure 4.08 called the Medical and Mental Health Alert process. The shelter maintained a large dry erase board with appropriate a three (3) color system to identify various medical/mental health and allergy conditions. The SN identifies Special Needs. An N is used to identify No special needs. A review of six (6) open residential files contained the appropriate General Alert risks which were documented on the dry erase board and the individual client files.

The agency's Work Shift Exchange Information forms and log book entries were reviewed to indicate staff members that were provided sufficient information and instructions regarding the residents' medical conditions, allergies and information to allow them to recognize and properly respond to the need for emergency care and treatment.

No exceptions are documented for the Medical/Mental Health indicator.

#### 4.05 Episodic/Emergency Care

Satisfactory                       Limited                       Failed

##### Rating Narrative

The shelter has a written procedure 4.08 called Episodic/Emergency Care. There were a total of eleven (11) injury or illness events documented as episodic or emergency events section in the last six (6) months. All injuries or events were documented in the Incidents Reports each quarter in a designated binder.

There were a total of two (2) episodic events documented and reported to the DJJ CCC and program log book. There was documentation for the parent/guardian notification requirement and obtaining off-site emergency services.

A review of staff member training files indicated that staff members had evidence of current CPR and First Aid certification, Fire Safety, Blood Borne Pathogens and Responses to Emergency Situations. At the time of this review, the shelter has a three (3) first aid kits in the residential shelter, wire cutters and a knife for life. There are are also first aid kits and fire extinguishers in all four (4) agency transportation vans.

No exceptions are noted for this Episodic Emergency Care indicator.