Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Capital City Youth Services

on 04/18/2019

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening of Employees/Volunteers	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	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/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity/Expression	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
3.08 Video Surveillance System	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%

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

Rating Definitions

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

Satisfactory Compliance	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.
Not Applicable	Does not apply.

Review Team

Members

Ashley Davies, Lead Reviewer/Consultant, Forefront LLC

Craig Swain, Regional Monitor, DJJ

Joel Booth, Executive Director, Anchorage

Sherri Swann, Clinical Director, LSF

Cyntoria Thomas, Program Manager, Thaise

Persons Interviewed

- [x] Chief Executive Officer
- [ ] Executive Director
- [x] Chief Operating Officer
- [ ] Chief Financial Officer
- [ ] Program Director
- [x] Program Manager
- [ ] Program Coordinator
- [x] Direct- Care Full time
- [ ] Direct-Care Part Time
- [ ] Direct-Care On- Call
- [ ] Volunteer
- [x] Intern
- [x] Clinical Director
- [x] Counselor Licensed
- [x] Counselor Non- Licensed
- [ ] Case Manager
- [ ] Advocate
- [x] Human Resources
- [ ] Nurse

0 Case Managers
3 Program Supervisors
0 Health Care Staff

0 Maintenance Personnel
0 Food Service Personnel

4 Clinical Staff
0 Other

Documents Reviewed

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

6 # Health Records
4 # MH/SA Records
7 # Personnel Records
8 # Training Records
8 # Youth Records (Closed)
8 # Youth Records (Open)
0 # Other

Surveys

5 Youth 4 Direct Care Staff

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

Rating Narrative

Residential:

The Shelter Manager (PJ Minzie) who has been with CCYS for 10 years, left the agency in July. The Management Structure was altered to have 2 new so- Shelter Managers, both who have worked in the shelter for 10 or more years.

The Nurse was terminated in August. Another was hired by October. He worked 1 day before resigning. Since that time the search has been on. Have had numerous applicants and interviews. The position still vacant.

More turnover occurred as the SNAP Program Coordinator, the Human Resource Manager, and the Outreach and Development Director all departed CCYS in the last quarter of 2018. The SNAP Case Manager (Greg Farmer) was selected as the new SNAP Coordinator. The HR Manager position remains vacant at the current time. A new Outreach and Development Director joined CCYS the first of March.

The program continued collaborating with local schools to try to get youth engaged in services early, especially those who have been suspended or are at risk of suspension.

Emphasis has been on increasing communication and collaboration between service providers to improve service delivery as well as increase care days. Staff members have worked with the JPOs (and attended the TRP Meeting), as well as attending the JAC steering committee.

New Shelter Managers have worked on environmental changes to continuously improve both the home- like fell of the shelter, as well as increase efficiency of the work environment for staff. Additionally, they have worked to improve the on-boarding process for new Youth Care Staff, as well as improve access to initial training.

There have been at least 7 Youth Care Specialist (Direct Care) staff departures.

While the shelter itself did not sustain damage during Hurricane Michael, several staff member were impacted by power outage for several days. Several of the counties in the service area (notably Liberty and Gadsden) sustained heavy damage. The shelter did see an increase in referrals from out of the catchment area, farther west, due to storm damage and the fact that their sister Shelter at Anchorage Children's Home was damaged.

The Clinical Director of Residential Services (over shelter and TLP) resigned in February. Within a month, the two Residential counselors did the same. Currently, the Clinical Director position has been filled by Julius Rainey, LMFT, who had previously worked in the non-residential Family Place program in Wakulla County. One of the counselor positions has been filled by Veronica France, who had previously been the Mentor in the Transitional Living Program and was completing her MSW internship in the shelter. The other counselor position remains vacant as of the first week of April.

Nonresidential:

Early in the fiscal year, they closed the CCYS Taylor County office in an attempt to facilitate meeting clients since the majority of services were being delivered in schools. The Taylor counselor moved to an office within the county school system.

The program obtained new office space in Wakulla County that is more centrally located within the county and has more space. The new building is able to accommodate three full time therapists and a full-time intern. It will also be used for SNAP clinical groups later in April.

A handful of staffing changes occurred including hiring a Mental Health counseling intern to fill a vacancy in Wakulla County.

The Taylor/Jefferson County YFA resigned in March 2019. In the new fiscal year, that position will include part-time services in Madison County.

Overall the strength of the program has expanded to include three LCSWs, one LMHC, and one LMFT. Clinicians have also expanded their skill sets with specialty training in EMDR, DBT, Trauma- Focused CBT, and play therapy.

The program continued delivering school based services in Leon County this school year, increasing the number of clients being seen in schools for individual counseling. Three elementary school engaged in Family Place services, and several more have expressed interest for the 19-20 academic year.

General /Agency

The Transitional Living Program was not awarded a federal grant, which was a loss of a revenue stream effective 9/30/18, which it has had since opening in 2013. However, the Shelter (Basic Center) and Street Outreach federal grants remain through this fiscal year.

CCYS partnered with two other agencies to share the "Sleep Out "event. They also moved the location of the event off the campus and to a

park downtown.

CCYS submitted its self-study in December and had its Site visit from the Council on Accreditation in February (the same week as licensing visit from DCF). The agency was bestowed full accreditation through March 2023.

The agency also held its annual Tally Awards event in early March. The event moved to a new venue for 2019. The agency has been doing this event for almost 10 years and the Board is considering the future of this endeavor.

Standard 1: Management Accountability

Overview

Narrative

The Capital City Youth Services (CCYS) agency provides residential and non-residential services to youth ages 6 - 17. The Some Place Else Youth Shelter residential facility is located in Tallahassee. The non-residential program provide services to the following counties: Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor and Wakulla.

The agency is under the leadership of Kevin Priest, Chief Executive Officer. Mr. Priest oversees a team of educated professionals that includes Gina Dozier, Chief Operating Officer; Nancy Hillger, Chief Financial Officer; and Justin Barfield, Outreach and Development Director. As COO, Ms. Dozier is responsible for the supervision of the following CINS/FINS positions: Julius Rainey, Clinical Director of Residential Services; Jason Ishley, Clinical Director of Non-Residential Services; and Mahogany Brown and Sarah Showers both who are shelter Program Managers.

A total of seven new staff were hired since the last QI visit. The agency trains all new and on-going staff as required using a combination of live instructor and online web-based training. In addition, the agency uses a training format that captures all training dates, topics, and hours that is maintained on each staff member.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Background Screening policy and procedures were implemented on February 1, 2018, by the Chief Executive Officer (CEO).

Prior to any individual beginning work or volunteering at the program, the programs conducts a level 2 background screening and a local law check on the individual as defined in F.S. 435.01-435.012. The program conducts the background screenings in compliance with the Department of Juvenile Justice and the Department of Children and Families regulations and protocols. All employees are required to receive a five-year rescreening. Only volunteers who exceed ten hours a month or who have unsupervised activities with clients are receive the background screening.

A review of the program staff and volunteer roster was conducted. Seven staff personal records revealed, the program completed the initial background screening on each staff member prior to their hire date. Fourteen intern records were reviewed for initial background screenings. In each record, the program conducted the background screenings prior to the interns start date. A review of two staff five-year background rescreens was conducted, both files documented the program submitted and received the five-year rescreening prior to the employee's five-year anniversary date. One five-year rescreen was conducted two months prior to the anniversary dater the other was conducted ten months prior to the anniversary date. None of the staff required an exemption. On January 24, 2019, the program received the annual affidavit of compliance with level 2 screening standards.

The program has not implemented pre-employment assessment tool.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Abuse Reporting, Client Grievance, and Client Rights policies and procedures were all implemented in December 2018, by the Chief Executive Officer (CEO).

During the intake and orientations process, client will review and receive a copy of their rights. It is the practice of the program staff to be sensitive and respectful with regards to race, ethnicity, sexuality, gender, religious preference, and medical and mental health and other needs of each youth in the program. All employees and volunteer at program are obligated by law to report any known or suspected cases of child abuse or neglect immediately. When staff become aware of child abuse allegations they are required to report the allegations to the Abuse Registry Hotline. Clients are free to report abuse at any time. Any suspected abuse or neglect involving program staff will is reported to the Abuse registry, program leadership, and the Department of Juvenile Justice's Central Communication Center (CCC).

Residents can at any time during their stay file a suggestion or grievance against the program, any staff or peers without fear of reprisal. Grievance forms are made available throughout the facility. Grievance forms are collected by residential supervisors and or program managers daily. The grievance process has two phases, formal and informal.

All program staff are required to sign a code of conduct acknowledging the use of physical abuse, profanity, threats, and intimidation are

prohibited. The program has the phone number to the Florida Abuse Hotline posted throughout the facility and visible for all youth to see. A review of nine staff training files confirmed the program staff are trained on child abuse reporting. The program maintains records of the calls to the Florida Abuse Hotline, along with the documentation of administrative review and necessary corrective actions to address incidents of abuse, verbal intimidation, use of profanity and or excessive use of force when applicable. The program has a locked grievance box available for youth in the common area of the facility. On the outside of the box, grievance forms are available for youth to complete and submit. Grievance forms are reviewed and signed by program supervisors and youth.

There were five youth surveyed. All five youth reported they knew the abuse hotline number but have never had a reason to call. All five youth reported staff are respectful. All five youth reported they have never heard staff use inappropriate language or threaten another youth. All youth felt safe in the shelter.

There were four staff surveyed. All four staff knew the procedures to allow a youth to call the abuse hotline. All four staff reported they have never heard a staff member deny a youth access to call the abuse hotline. All staff reported they have never heard a co-worker use profanity, threats, intimidation, or humiliation when speaking to the youth.

There were no exceptions to this indicator.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Incident Reporting policy and procedures were implemented on December 1, 2018, by the Chief Executive Officer (CEO).

The programs practice is to convey critical information concerning significant safety and liability issues to assure prompt attention is made by management. Program staff are required to complete an internal incident report within 24 hours of the incident, if the Incidents is required to be reported to the Department of Juvenile Justice's Central Communication Center (CCC). Incidents which require a CCC report are listed in the supervisors' office and are required to be reported within 2 hours.

A review of the CCC reported for the past six months, revealed six CCC were reported. One incident was reported after the 2-hour timeframe. On January 12, 2019 at 7:00 AM, the program's experienced difficulties providing a youth medication due to a malfunctioning lock. According to the CCC report the youth was given the medication at 10:00 AM and the report was called in at 10:27 AM. Each CCC report was logged and documented on the incident reporting form along with the communication, instructions, and/or the necessary follow-up as required by the CCC. Each CCC report also contained the signature of program leadership acknowledging the report was reviewed.

There were no exceptions to this indicator.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program implemented a training calendar for the 2018-2019 Fiscal Year.

The training calendar requires all staff to complete 80 hours of training during their first year of employment and all staff to complete additional 40 hours annual training thereafter. Supervisors staff are required to complete 8 hours of management training. The plan outlines all of the trainings required within the first 120 days of employment and the trainings required to be complete within the first year of employment. The training plan also outlines the Department of juvenile justice SkillPro Learning management requirements.

A review of three staff training requirements for the first 120 days revealed each staff completed all training as required timeframe. Of the three files reviewed, one staff completed a total 103 training hours. One employee completed a total of 75 training hours, however, has three months to complete the remaining training requirements, the other staff completed a total of 79.5 training hours and their anniversary date was April 4, 2019. Of the threes staff records reviewed, none of the staff completed cultural humility, one staff did not complete Title IV procedures.

A review of five staff annual training was conducted. Each staff completed all of the required annual training as required with the following exceptions: One staff did not complete managing aggressive behavior training and one staff did not complete CPR/First Aid training within the required timeframe.

Cultural humility is not documented in any the three first year staff training records.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Analyzing and reporting information policy and procedures were implemented in April 2018, by the Chief Executive Officer (CEO) designee.

The program collects data and review several sources of information. Staff are required to enter clients information into NetMIS/HMIS. Program leadership review monthly reports and communicate findings to staff. Annual outcome data is reviewed, along with client records, Incident reports, and grievances forms.

There were no exceptions to this indicator.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has an established Transportation Policy that encompasses all of the required elements of Quality Improvement Standard 1.06. The policy is current and was reviewed by the CEO on December 2018.

The program's policy in place guarantees the safe use and responsible maintenance of the agency vehicles for Capital City Youth Services. Only staff properly licensed, insured, and approved by insurance company and agency administration may operate CCYS vehicles.

Email documentation from the insurance carrier was provided that confirms all employee driver records are reviewed annually for confirmation of employee eligibility to transport clients. This same process is completed for all new hires.

A review of the agency's vehicle log confirmed that it documented the initials of drivers, date and time, mileage, number of passengers, the purpose of travel and location. There is also a column that is initialed by the supervisor when single transport occurs. All single client transports were documented on the transportation log by the circling of yes for supervisor approval and the number of youth transported being indicated as one. A review of the logbook confirmed that staff made entries into the log book when departing with youth for transports; entries made into the vehicle transport log correlated with the log book entries.

At the time of review, several staff were interviewed about the transportation process and it was reported that the supervisor is aware prior to the transportation taking place of the route and which kids are being transported.

Transportation logs record when there is a single youth transport. A column is designated on the transportation log documents that supervisor approval was received prior to transport. However, no additional documentation is present to support that the supervisor was aware prior to the single client transport occurring (i.e. log book documentation showing supervisor approval or some other form of supportive documentation).

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency provided a copy of its 2018-2019 Outreach Plan.

The plan had five well established goals that focused on maximizing the utilization of CCYS services in the community to reduce juvenile delinquency through a variety of its intervention and treatment services. Goal 3 of the Outreach Plan specifically highlighted the use of Cooperative Service and Interagency Agreements, involving CCYS staff on Juvenile Justice Boards, Councils and other advisory groups, and attending interagency groups to stay connected to the community and its current needs.

Meeting agendas and minutes were provided that documented attendance at the local Circuit 2 DJJ Advisory Board meetings, Circuit 2 RED/DMC meetings, JAC Steering Committee Meeting, the Wakulla County Coalition for Youth, and the United Partners for Human Services meetings.

CCYS has a very active social media and online platform. They utilize their agency website, Facebook, Twitter, and Instagram. Netmis data provided documentation of over 100 outreach events that disseminated information about the program services to over 1,000 children and 540 adults.

A binder was provided that contained a plethora of MOU's and working agreements between CCYS and its community partners. An Outreach and Development Calendar and a copy of their visitor's log was reviewed which provided solid documentation that CCYS works extremely hard

to maintain a presence in its community; ensuring that its community partners have access to the services provided by the agency.

There were no exceptions to this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The Non-Residential program is under the direct supervision of a Licensed Mental Health Counselor (LMHC). The Non-Residential LMHC supervises a counseling team comprised of seven full-time Counselors and five interns. The Non-Residential program services client needs across several counties. Several of these counties are in rural and outer-lying areas. The agency provides several services. The referrals for services are received from parents, school, counselors, the court system, the youth themselves and other sources. The services provided by CCYS include individual, family and group counseling along with case management services. Case management services include life skills, social skills and referrals for services upon the youth's return to the home/community. Youth also receive referrals for substance abuse and mental health services.

The Residential program is under the direct supervision of a Licensed Marriage and Family Counselor (LMFT). The Residential LMFT supervises a team comprised of 2 staff members including 1 full-time counselor and 1 Program Support Specialist. There is also 1 full-time counselor position vacant.

A CINS/FINS screening is conducted on each youth prior to their entry into the facility to determine if they are appropriate for the program. Trained staff are available to determine the needs of the family and youth. A needs assessment is then conducted on each youth to ascertain what services they will need to be provided. The youth and family participate in a face-to-face session in order for the staff to assess their individual needs and develop an individualized plan of services to accomplish specified goals. After completion of the needs assessment a case/service plan is created to address these issues. Residential counseling services including individual, family, and group therapy are provided. In addition, case management and substance abuse prevention services are offered in non-residential settings. Referral and aftercare services begin when the youth are admitted for services. Aftercare planning includes referring youth to community resources, ongoing counseling, peer support, advocacy, financial assistance, housing assistance, and educational assistance.

CCYS leads and coordinates the Case Staffing Committee—a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The case staffing committee may include representatives from the school district, DJJ or CINS/FINS provider, State Attorney's Office, Mental Health and Substance Abuse organizations, law enforcement and DCF. The Case Staffing Committee meets monthly and can also recommend a CINS Petition be filed to court-order participation with treatment services.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Policy and procedure for screening and intake was last updated in December 2018 and was approved by the CEO. The policy includes the required elements of 24/7 access to services, screening by trained staff, and need for screening within 7 calendar days of referral.

Screenings for shelter services are conducted 24/7 and are completed by all trained staff. Screenings can be conducted by phone or in person and are recorded on the CCYS Screening Form. For shelter services, the screening form is considered the referral for services.

During a shelter intake a client is given a Client Informed Consent Form, Rights & Responsibilities Form, and a CINS/FINS Brochure, which contains available service options. The Intake procedure for clients is considered initiated with the completion of the Intake and Assessment Form.

The shelter intake documentation is inclusive of all the elements required to meet the standard, including client rights and responsibilities, written information about service options, grievance procedures and acknowledgment from parents that they received the Parent/Guardian Brochure.

There sixteen files reviewed, eight residential files and eight non-residential files.

All sixteen files documented the eligibility screening was completed within seven calendar days of referral. For Non-Residential services, a screening is conducted in response to written referrals, by phone or in person. Once a written referral is received, a counselor will attempt to contact the family within 48 hours to arrange an intake appointment. If the family cannot be reached a letter will be sent offering services. There was documentation the youth and parent received in writing: available service options, rights and responsibilities, and the parent/guardian brochure. The youth and parent also received information on possible actions occurring through involvement with CINS/FINS services and grievance procedures.

An interview was conducted with the Non-Residential Clinical Director and Residential Manager. The intake process and procedures were

explained.

There were no exceptions to this indicator.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a policy in place for the Needs Assessment that was last reviewed by the CEO in December 2018.

The Needs Assessment consists of three parts: Someplace Else Intake & Assessment Form; The Needs Assessment Form; and the Needs Assessment Summary. For shelter youth, the Intake Form is completed upon arrival and the full Needs Assessment is turned in to the Clinical Director within seven calendar days of the youth's intake for signature.

For both residential and non-residential services, if the Needs Assessment indicates an elevated risk for suicide, an Assessment of Suicide Risk is conducted and is reviewed by a Licensed Mental Health Counselor.

There were sixteen files reviewed, eight residential and eight non-residential.

In all files the Needs Assessment was started the same day as admission to services, and was completed within two to three face-to-face sessions. All Needs Assessments were completed by Master's level counselors and were signed by a supervisor. Two files had an elevated risk for suicide as a result of the Needs Assessment and it had the required Suicide Risk Assessment completed and signed by a supervisor. The summary section of the Needs Assessment is a comprehensive write-up and addresses current and past issues affecting the youth, his/her current level of suicide risk, and reported strengths/likes and goals. The signatures on the Needs Assessment denote the counselor's degree level and supervisory review.

There were no exceptions to this indicator.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The policy and procedure for Service Plan Development was last updated December 2018 and was approved by the CEO.

Plans of Service (POS) are developed within seven working days of the Needs Assessment. POS are individualized based on issues identified at screening. POS forms include service type, frequency, location, persons responsible, target dates, completion dates and signatures of youth, counselor, parent and supervisor. The form also includes space for documentation of the date the plan was initiated.

There were sixteen files reviewed, eight residential and eight non-residential.

All eighteen files reviewed had a Plan of Service (POS) developed within seven working days of the Needs Assessment. The POS in all files reviewed contained individualized and prioritized goals, service type, frequency, and location, persons responsible, target dates for completion, signature of the youth, parent, counselor, and supervisor.

All required thirty day reviews of the POS were completed as required with the counselor and parent.

There were no exceptions to this indicator.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Case Management and Service Delivery. The policy was last reviewed and updated in December 2018 by the CEO.

For non-residential services, counselors are assigned to a case in response to screenings. As part of the assessment process counselors establish a Plan of Service (POS) and immediately begins coordinating services to meet client needs. The POS form and chronological record is used to document client needs and efforts made to engage and support youth and families. At discharge from services, an Aftercare Planning and Referral Form is completed and provided to families.

When warranted a referral to the Case Staffing Committee is made and the Committee is convened to assist the youth and family.

Follow-ups are completed for all cases at 30- and 60-days following case closure.

There were sixteen files reviewed, eight residential and eight non-residential.

All sixteen files documented a counselor was assigned to the file. There was documentation referrals for services were made as needed. All files documented the counselor coordinated implementation of the Plan of Service (POS), monitored the youth and family's progress in services, and provided support for families. None of the files required any monitoring for out-of-home placement or referral to the case staffing committee.

The Clinical Director of Residential Services explained that the shelter chooses from a list of 10 Basic Target Skills to help youth better manage their problem behaviors. Reference to this list is noted via “Mastery of Target Skills” on the POS.

All closed files reviewed included an Aftercare Planning and Referral Form, which is provided to the family, and a Discharge Plan, which summarizes the services and referrals made. All thirty and sixty day follow ups were completed as required.

There were no exceptions to this indicator.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Requirements for this indicator are covered under the Service Modality & Intervention Policy, The Chronological Records & Case Notes Policy; and The Group policy. Revisions were done in December of 2018 by the CEO.

Master's level counselors and/or interns utilize The Needs Assessment, Plan of Service (POS), and Plan of Service Reviews to address youths' presenting problems. Chronological notes are used to document client activities, sessions, phone calls, and collateral interventions. SOAP notes are used to document individual and family sessions. The primary service modality is individual counseling and family counseling is available if a family request it.

There were sixteen files reviewed, eight residential and eight non-residential.

All files addressed the youth's presenting problems in the Needs Assessments, Plans of Service (POS), and Reviews, as appropriate. Chronological notes documented services provided and any progress or lack of progress. The youth and families were receiving counseling

services in accordance with the POS. There was also documentation the youth were receiving individual counseling as needed. Signatures of licensed supervisors throughout the records and interviews with counselors, supports an internal process of clinical reviews and weekly supervision.

The eight residential files contained documentation of group counseling at least five day per week. The Group Log is used to document group activities. The groups were at least thirty minutes in length, documented a clear facilitator, documented a clear and relevant topic, and provided an opportunity for youth engagement.

There were no exceptions to this indicator.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Requirements for this indicator are covered under two policies, the policy for CINS/FINS Case Staffing Committee and the Case Supervision Policy. These policies were last reviewed in December 2018 and approved by the CEO.

A Case Staffing Committee is convened in response to a referral. The Non-Residential Clinical Director coordinates the meetings with the assigned counselor. Parents/Guardians and Committee members are notified no less than five days prior to the Case Staffing Committee. The Chronological Record shows documentation of all the contacts for this process. The meetings are documented using the Case Staffing Committee Recommendation Form, which is signed by all parties present and includes recommendations and plans for the family. Prior to the end of each meeting the form is copied and provided to the family being reviewed.

There was one file available for review. The referral to the Case Staffing Committee was made by the Residential Counseling Team. Documentation on the Chronological Record and the Case Staffing Committee Recommendation Form was used to verify the family and committee was notified no less than five working days prior to the staffing. As a result of the Case Staffing Meetings, recommendations were made that included continuing the current Plan of Service (POS) and referring to additional services. A copy of the recommendations was signed and provided to the family following the meeting, well within the seven day time frame. The file showed consistent documentation supporting the CINS/FINS Case Staffing Process. The committee meets only as needed.

There were no exceptions to this indicator.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

This indicator is covered under two policies: Confidentiality of Client Information and, Record Retention Policy. Both policies were reviewed in December 2018 and were approved by the CEO.

The confidentiality policy states the program complies with all applicable federal and state statues and codes with regard to confidentiality of records. The policy further explains that all files are marked confidential and outlines details of when and how information is released. The record retention policy states client records will be maintained in a confidential manner and accessible only to authorized CCYS staff. The policy also states records are to be secured in lockable filing cabinets when not in use.

Each youth admitted to a program is given an individual client file, marked confidential and maintained in a specific and consistent manner. Each record contains only his/her name and information. The records are maintained in a locked room marked confidential, in file cabinets also marked confidential. Only designated staff have access to the locked files. When files are transported, they are maintained in lock boxes, marked confidential.

All files reviewed were marked confidential and were maintained in a neat and orderly manner. The open files were maintained in folders with separate tabs for ease of access. The file room and file cabinets were marked "confidential". The files are transported in opaque, locked boxes that were also marked "confidential".

There were no exceptions to this indicator.

2.08 Sexual Orientation, Gender Identity/Expression

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has eight different policies to address the requirements of this indicator. The policies used included: Access and Eligibility Criteria/Referral Process, Behavior Management, Dress Code, Clients Rights, Hair and Beauty, Hygiene, Room Assignment, and Services Offered. All these policies have been reviewed in the last calendar year by either the Chief Executive Officer or the Chief Operating Officer.

Procedures in place ensure youth are address according to their preferred name and gender pronouns and that the youth's preferred name and pronoun are used in the logbook and all outward facing documents. The youth's preference is to be considered and documented for room assignment. The youth will receive hygiene products and clothing that affirms their gender identity or gender expression. The program will have signage placed in common areas indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression.

The shelter has copies of the Zine located in the main lobby for staff and visitors to take and read. There was also documentation that all staff had received training on the SOGIE policy and various different trainings related to the LGBTQ community. This was documented in the staff training files.

The shelter has signage located throughout the shelter including in the staff offices, lobby area, and dayroom indicating the program is a safe space for all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression. The program's screening form used at intake has been updated to ask the youth their sexual orientation, preferred pronoun, and name/nickname used.

The shelter has had one youth who identified as a transgender male in the last six months. This youth was admitted twice during the last six months. Both times the youth's preferred name and pronoun were used on all documents and in the logbook. The sleeping rooms in the shelter are not assigned a gender and are not separated between male and female. The youth was able to sleep in a regular room and was not isolated. The youth was able to wear any gender clothes they chose, at times the youth chose to wear female clothes and at times the youth chose to wear male clothes, depending on what the activities for the day were. The program utilizes Going Place to referral the youth for specialized support. The referral form was found in the file.

There were no exceptions to this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The SPE shelter provides short-term respite residential services to youth ages 6-17 in the Department of Juvenile Justice (DJJ) CINS/FINS program as well as for youth from the Department of Children and Families. The SPE youth shelter is designated by the Florida Network of Youth and Family Services to provide staff secure services, Domestic Violence (DV) respite, Probation Respite, Family/Youth Respite Aftercare Services, and Domestic Minor Sex Trafficking.

The shelters program management team is comprised of two Program Managers and one Residential Supervisor. There are a total of nine full time and four part time Youth Care Specialist positions in the shelter program. There are also two residential counseling positions.

The CCYS SPE youth shelter building includes a large day room, individual girls' and boys' sleeping rooms, individual bath rooms, kitchen, laundry, residential and counseling staff offices. The exterior of the office includes a large outside basketball and recreation area. During the Quality Improvement review, the shelter was found to be in clean and good condition. The furnishings are in adequate condition and the rooms and common areas were clean. The bathroom floors are tiled and the plumbing appeared functional. The sleeping rooms houses two - three youth each. The sleeping room is equipped with individual beds, bed coverings and pillows. The windows are equipped for privacy for the youth.

The program has policies and procedures in place for its Shelter Care programming. The Direct Care workers are responsible for completing all applicable admission paperwork conducting youth orientation to the shelter, and providing necessary supervision. Health and medication related activities are the responsibility of the staff. Oversight of clinical services is provided by both the residential and non-residential Licensed Clinicians.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A Daily Youth Schedule Policy is in place that was reviewed and signed by the CEO on December 2018.

The agency is to provide a clean, well-maintained program. The youth shall be provided an individual bed and clean coverings. The lighting is to be adequate. A safe shall be provided to keep personal belongings, if requested. The youth will be offered a variety of activities that include faith-based activities and activities to keep them active and involved which includes opportunities for physical, mental, and social maturity through exposure.

A schedule shall be posted publicly and accessible to youth and staff. Records of a current health and fire safety inspection were reviewed.

Physical activity, food safety/security, program based activities, nutrition guidelines, and snacks are implemented in the program. The agency utilizes direct care staff to prepare and serve food. Training is provided regarding health and nutrition. Youth participate in creating menus for cultural studies. Special dietary needs are addressed upon intake. The USDA National School Lunch Program is followed.

A tour of the facility was conducted and all furnishing were in good repair; no graffiti was found, lighting was adequate, the exterior grounds were in excellent shape; the campus is beautiful. Individual beds were observed with clean linen and sufficient blankets. Detailed egress plans were posted throughout the facility to include each individual bedroom. A current DCF licensed is placed in the lobby area. All required postings were found on the bulletin board in the general living area. Youth personal items were locked in a filing drawer behind the counter in the Youth Care Specialist office.

An annual fire inspection report was provided confirming that an inspection was conducted by the Tallahassee Fire Department on July 10, 2018. Fire extinguishers were also inspected in July 2018. Fire drill logs were provided that verified monthly fire drills on each shift had been consistently completed. Mock emergency drills had been completed quarterly on each shift which was confirmed by the emergency drill log sheets. MSD sheets were provided along with a daily inventory of cleaning supplies.

All food was properly stored and labeled in the refrigerator, freezers, and pantry area. The refrigerator/freezers were clean and at the appropriate temperature. An annual health inspection report was completed on 2/14/2019.

A daily schedule was posted in the common living area that clearly identified blocked time in meaningful, structured activities seven days a week. The schedule included one hour of physical activity per day, social skills training, etc. A living area with couches was accessible to youth that had several book shelves that were full of books for the youth to enjoy in their leisure time.

There were no exceptions to this indicator.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Client Rights Policy that was reviewed and signed by the CEO on December 2018.

The program uses several forms to support the completion of the orientation. The main form used is the Youth Orientation Checklist and Room Check-In, which is a check list of all the items covered and is signed by the youth and staff at the time of completion. The program also uses other forms such as the Someplace Else Youth Contract and Someplace Else Program Overview and Guideline.

The shelter utilizes the Someplace Else Youth Contract to discuss the youth's rights and responsibilities while staying in the shelter. The Program Overview & Guidelines discusses some client rights including: family involvement, length of stay, and the behavior management system that is implemented. Additionally, a Youth Orientation Checklist and Room Check-In sheet is utilized to document when the youth received orientation. This checklist covers all required orientation components outlined.

A review of five current client files confirmed that the above practice was consistently implemented during the time of intake. All five files reviewed contained a completed Program Overview & Guidelines sheet, a Youth Contract, and a completed Orientation Checklist. All forms were completed the same day of the youth's intake date. An interview with the Shelter Manager, was conducted and she reviewed the intake process and highlighted the orientation checklist and process that is used to complete the checklist. The list of contraband items is located on the bulletin board in the living area and all youth are shown this list. Youth handbooks are provided to all youth entering the shelter which provides an additional avenue for this information to be obtained by the youth. The handbooks are placed in baskets on the bedroom doors so youth can access them at their leisure.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The shelter has a Room Assignment policy in place that was reviewed and signed by the CEO on February 2018.

The shelter uses the information gathered on the Someplace Else Intake and Assessment Form to determine room assignment. The form covers all the required area to make an appropriate assessment as to which room a youth should be assigned up on their arrival at the shelter. The shelter also uses several forms to indicate any alerts, based on the CCYS Residential Alert System Sheet, a youth may have; these include the Someplace Else Intake and Assessment Form, Contact Authorization Form, File cover, and Medication Schedule Overview.

The shelter utilizes their Screening & Eligibility form and Intake & Assessment Forms to document screening criteria to determine room assignments. All required screening categories are covered to help identify potential safety and security concerns to be utilized in the room assignment process.

A very well defined alert system is utilized as youth enter the shelter. A colored dot system is used to alert staff of a youth's potential risk; the dot is placed on the spine of the youth's file. Notes are entered into the youth's file describing the potential risk and what steps were implemented to mitigate the identified risk. In addition to documentation in the client file, further documentation is also entered into the electronic log book as part of the youth's intake summary which alerts staff to a youth's potential risk as they enter the shelter.

The above process was confirmed by reviewing four open case files. All files contained documentation of a thorough screening process to help identify appropriate room assignments. The alert system was also consistently implemented in all four files and the appropriate colored dots were found on the spine of the youth's file. An interview with the Shelter Manager, was conducted and she was able to very clearly articulate the screening process for room assignments and the alert system. An additional interview was completed with a Youth Care Specialist and he was also familiar with the alert system in place and clearly defined the dot system and where the dots were located for quick reference.

There were no exceptions to this indicator.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Log Book policy that was updated and signed by the CEO designee on April 2018.

The shelter has a clear policy on what and how information should be noted in the log book. The different highlights used are: orange for youth

behavior, yellow for parent/guardian, pink for medication, blue for Law Enforcement, purple for administrative, and green for safety. The shelter highlighted items related to safety and security. Reviews of the log are to be conducted by the program director or designee, oncoming supervisor and direct care staff in the unit indicating he/she have read and reviewed, dating each review.

The facility utilizes an electronic log book. A review of varying time periods going back to January 2019 confirmed consistent documentation in the log book. All entries included date and times of the incident, event or activity, names of the youth and staff involved. The recorded entries were concise and obtained pertinent information. All entries were followed by the signature of the person making the entry. Youth Care Specialist coming on shift documented reviews of the previous two shifts. No errors that required a single line strike through were observed during the time period reviewed. Pertinent security concerns and alerts were highlighted in the colors that are stated in the agency log book policy and procedure.

Supervisors coming onto shift consistently recorded reviews of the previous two shifts and specifically notate the date period reviewed. The Shelter Manager also consistently completed weekly reviews and notated the time period reviewed with specific date ranges. The electronic log book appears to be very well integrated into the daily operations of the shelter. All staff were comfortable navigating the log book as well as their supervisors.

There were no exceptions to this indicator.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a policy in place for Behavior Management Strategies that was last updated October 2018 and was approved by the CEO.

The policy includes a detailed description of the Behavior Management System (BMS) and notes that staff receive comprehensive instruction on it during a formal orientation training week. The policy indicates that youth shall not be denied any rights such as clothing, food, shelter, access to medical care or contact with family/involved professionals as a form of punishment. The policy indicates that the BMS is designed to promote a safe and trauma informed therapeutic environment that eliminates the need for physical and/or restrictive behavioral interventions.

The policy outlines the practice of utilizing collaborative problem solving with youth in order to effect positive change. This process encourages critical thinking and healthy decision making skills to assist youth in getting their needs met.

During an interview with the Shelter Manager she explained the practice of informing youth of the BMS during the intake. She provided a copy of the Youth Contract, where the BMS is explained, which is signed by each youth, intake staff, and supervisor. All shelter files reviewed contained the Youth Contract. The Shelter Manager explained the program doesn't use a reward system; rather, they utilize collaborative problem solving, positive reinforcement, and natural consequences. Sarah explained that staff are trained on the BMS during their initial job shadowing, as well as, during Quarterly 5-day Orientation training sessions. She provided a copy of the Spring training schedule that included a variety of topics, including: Why Try and Collaborative Problem Solving, which are both part of the BMS. The Shelter Manager explained that staff receive feedback on their use of the BMS as part of their daily conversations, supervision sessions, and during performance reviews.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The policy for Supervision of Clients & Staff Responsibilities was last updated February 2017 and was approved by the CEO. The policy doesn't mention details about the staff schedule, how it is provided to staff or where it's posted.

The policy notes the 1:6 staff to client ratio during awake hours and 1:12 during sleeping hours. The policy indicates there is a minimum of one male and one female staff member on duty at all times, and outlines staff responsibilities for each shift, including the bed checks.

During an interview with the Shelter Manager she confirmed the staff to client ratio procedures, including the practice of having at least one male and one female staff on each shift. She shared copies of the color coded staff schedule, which indicates male and female staff coverage and includes a listing of all the staff members and their phone numbers to be used to fill gap coverage if needed. The Shelter Manager also explained that the schedule is emailed to staff and is also posted in the counselor hallway in the shelter. Regarding staff observations of youth in their sleeping room, she provided Bed Check Logs that showed bed checks completed in ten minute intervals during sleep hours.

A review of the staff schedules verifies the male and female staff of each shift and shows the staff names and phone numbers at the bottom, for ease of access for shift coverage. Review of the Bed Check log documents routine bed checks in ten minute intervals.

Review of three random date and time selections of the surveillance cameras showed consistency in bed checks, as well as, the male and female on each overnight shift reviewed.

There were no exceptions to this indicator.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There are two policies in place to address the requirements of this indicator, CINS Staff Secure which was last reviewed December 2018 by the COO and Special Populations that was last reviewed April 2018 by the CEO, Kevin Priest.

Access to staff secure shelter services shall occur after other alternative, less restrictive remedies have been exhausted by the provider in cooperation with the case staffing committee as per Florida Statute 984.12. All youth receiving staff secure services will receive the same living arrangements as specified in temporary shelter placements. Staff secure youth should be clearly distinguished from other shelter youth including more comprehensive assessments and one-to-one supervision during awake hours for the youth during each shift to monitor the location and movement of the staff secure youth at all times.

Domestic Violence Respite Care Services shall be provided to both male and female youth ranging from 10 years of age and up to 17 years of age, who have been charged with an offense of domestic violence. Eligible youth shall include youth who have been charged with domestic violence as well as previously adjudicated on other charges besides domestic violence.

Probation Respite Care Services shall be provided to both male and female youth ranging from 10 years of age and up to 17 years of age, who are currently on probation regardless of adjudication status and referred by the Department’s Juvenile Probation Officer.

Staff Secure: The program had one case to review from the last six months. The youth referred to Staff Secure was referred according to the F.S 984, per a court order. The staff schedule and Note Active document the one-to-one supervision, as indicated by the word “CINS” next to the staff name. In this case, the judge has not yet requested a progress report from the youth’s stay in shelter.

Domestic Violence (DV) Respite: There were three cases to review from the previous six months. In all three cases the youth was admitted as a result of the DV charge, was screened by JAC/Detention, and did not exceed the 21 day stay. One youth left the program after only one day and therefore didn’t transition to other services, but the other two youth transitioned to appropriate referral sources. The Case Plans reflected a focus on aggression management to reduce re-occurrence of future violence. Each of the youth received services consistent with CINS/FINS program requirements, including intake assessment, case management, meals, and program activities.

Probation Respite: Four files were reviewed from the previous six months. Three of the four included a referral from DJJ Probation. The other was a referral from the mother. Length of stay in all cases was within the thirty day time frame. Two of the youth ran during the intake; but the other two cases had evidence of case management and counseling needs being addressed, as well as evidence of all other services provided consistent with all CINS/FINS general requirements.

Family/Youth Respite Aftercare Services: There was one file to review. The youth was approved for services from the Florida Network, as indicated on the Network Referrolator, was on probation, and was at-risk of violating. The intake and initial assessment sessions met the required criteria of being face-to-face to collect family history and demographic information, as well as, documenting development of the service plan and orientation to the program (as indicated by a signed service plan). The youth was referred for individual counseling, as there were no issues noted within the family. Individual sessions and treatment goals focused on establishing life plans for after graduation and on developing positive coping skills.

There were no cases in the last six months for Domestic Minor Sex Trafficking. And the agency does not provide Intensive Case Management Services.

The program doesn't have a specific policy for Family/Youth Respite Aftercare Services.

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The requirements of this indicator are covered under the policy Alarm and Security System. The policy was last updated February 2017 by the

CEO.

The program has a video surveillance system that is in operation twenty-four hours a day, seven days a week. The system can capture and retain video photographic images for a minimum of thirty days. The cameras are located in general locations of the shelter where youth and staff congregate and where visitors enter and exit. The video surveillance system is only accessible to designated personnel in the facility. If requested by a third party (Law Enforcement or CCC) the video system is made available to them. The supervisors review and document review of video at minimum once every fourteen days.

The program has written notice of the surveillance system posted conspicuously at the shelter entrance. The surveillance system includes 16 cameras in the interior and exterior of the shelter, in general locations where youth, staff, and visitors congregate. Cameras are visible and are not placed in bathrooms or sleeping quarters. The system has capacity to retain video for 30 days. While facial recognition is not clear, a person can easily be identified by physical characteristics and clothing. The cameras work during power outages, as they are connected to back up batteries. There is a list of designated personnel who can access the video surveillance system. Supervisory review of the video was completed every 14 days in the last 6 months with the exception of October and November, where there was only one review each month.

The surveillance system was utilized to review staff completing bed checks. While the time stamp was off and there was inconsistency with the camera performance, there was sufficient coverage to document consistency with the bed checks.

There were no exceptions to this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The CCYS agency has detailed policies and procedures related to the screening, health admission screening, classification, assessment and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. All youth receive an initial assessment to determine the youth's risks, needs and issues. Based on this information, the youth is assigned a room which can change after further assessment.

All staff members are trained on risk screening methods that immediately identifies youth who are admitted with special needs and risks—such as risk of suicide, mental health, substance abuse, physical health (acute and chronic), or security risk factors. Once risks are identified through the screening and assessment process all staff and management are notified. The youth is placed on alert status. The agency takes steps to ensure that measures are taken to maintain a safe and secure placement; and supervision is provided by direct care staff during the resident's shelter stay. The agency maintains a program log, general alert system, pass down/shift exchange forms, and other notification systems. Youth admitted to the shelter with prescribed medications are also provided their medications during their shelter stay.

Staff members participate in routine mock emergency drills and receive orientation and annual training courses that include Universal Precautions, Safety, and General Program Risk Management training.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place titled Health Screening on Admission to address the requirements of this indicator. The policy was last reviewed by the Chief Executive Officer in February 2017.

The Intake and Assessment form is to be completed upon admission. Information documented on this form is to include acute or chronic mental health, health, or substance abuse issues, medications, allergies, illnesses/injuries, and staff observations of the youth. Within five days of admission the Registered Nurse will review the medication/health screening and medication inventories.

There were five residential files reviewed. All five files documented the Intake and Assessment form was completed at admission. Four of the youth were documented as taking medications, one youth had a allergy to pollen, two youth were noted as having Asthma in the past but neither youth used an inhaler, one youth had an inhaler but did not have Asthma. None of the files reviewed documented the youth had any chronic condition requiring a follow-up medical appointment. The shelter does have procedures in place in case a youth does require a follow-up appointment. The youth's parent/guardian is responsible for any follow-up medical appointments, if the parent is unable to transport the youth then staff shall transport the youth. If the parent/guardian refuse medical treatment or cannot be contacted, staff shall contact DCF who will then request an ex parte court order authorizing medical treatment.

Due to the shelter not currently having a Registered Nurse (RN) none of the physical health screenings were conducted or reviewed by an RN within five business days.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a policy in place for Suicide Prevention that was last updated December 2018 and was signed by CEO.

The policy covers screening, identification, and response to youth at-risk of suicide. The policy details the steps shelter staff take while interacting with youth. It includes assessing for suicide risk, placing youth on constant sight and sound supervision, documenting the details in the file, and contacting the appropriate licensed staff to conduct the suicide assessment. The policy does not contain language that ensures the level of youth supervision is not changed or reduced until a licensed professional completes the suicide assessment.

Youth identified as suicidal prior to intake are referred to Tallahassee Memorial Behavioral Health Center. Otherwise, youth are given a risk of harm assessment at intake. If the youth answers positively on 1 of 6 screening questions, the youth is placed on constant sight and sound supervision until they can be given a suicide assessment by a licensed professional. During sight and sound supervision, staff document youth safety in ten minute intervals during sleeping and quiet time hours. Green sheets are used to document quiet time from 2:30 - 3:30 pm. Pink sheets are used for youth who are in their room due to illness and white sheets are used for the overnight, sleeping hours. The level of supervision is not changed until the licensed professional has indicated it is safe.

There were four files reviewed, two open and two closed. All files included a suicide risk screening completed at intake. The results were signed

by the supervisor and documented in the youth's file on the Chronological Record. In all cases reviewed, the youth was placed on sight and sound supervision until they were assessed by a licensed professional. Staff were assigned to monitor the youth and observation checks were documented in ten minute intervals until they were removed by the licensed clinician.

There were no exceptions to this indicator.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled Medication to address the requirements of this indicator. The policy was last reviewed in December 2018 by the Chief Executive Officer.

There are procedures in place for receiving medications, storage, prescription drug information, assisting youth with self-administration of medications, prescription medication, prescription allergy/asthma medication, non-prescription medication, record keeping and documentation, inventory, disposal, school issues, and staff responsibility.

At the time of the on-site review the agency did not have a Registered Nurse (RN) employed. The position has been vacant since August 2018, with the exception of one day in October 2018, when a RN was hired and worked for one day before quitting. Since then the agency has attempted to hire a RN through job postings on Indeed, Nurse Finders, recruiting within the community, and working with staff at the Florida Network. Since October 2018 the agency has had at least twelve applicants and interviews that have resulted in the applicant not being qualified for the position or not accepting the position due to the part-time hours. For the past six months the agency has made numerous repeated attempts to fill the RN position with no success. At the time of the review there were currently two applicants who had been interviewed, within the last three weeks, the agency was attempting to contact to offer the position to one of them. There was documentation of dates and times phone calls had been made to the applicants with no call back. There were numerous emails reviewed from the last six months between the agency and applicants and staff at the Florida Network, attempting to recruit a qualified nurse for the position. Resumes were also reviewed on-site of applicants who were interviewed and not hired, also applicants who were interviewed but did not accept the position, and applicants who submitted resumes but did not qualify for an interview. Each resume reviewed documented notes from the interview, a search of the applicant's license, and any other information found on the applicant. If the applicant was not qualified for the position this was documented as well, with the reasons why.

The agency provided a list of eighteen staff who are trained to supervise the self-administration of medications. There were three staff who were identified as Super Users listed, including the Program Manager, Residential Supervisor, and Shelter Support Specialist. The Super Users are responsible for training all staff and new hires on the medication administration process and the use of the Pyxis Med-Station.

All medication is stored in the Pyxis Med-Station. Over-the-counter medications and razors are stored in drawer one, prescription medications are stored in drawer two, three, and four, and drawer five is used for oversized medications or refills. Medications are verified at admission by the staff calling the pharmacy to verify.

At the time of the review, there were three discrepancies open. One discrepancy was from the day of the review, one was from three days prior to the review, and the last one was from seven days prior to the review. Staff interviewed reported discrepancies should be closed by the end of the staff's shift and that most of the time they are. Staff knew the procedures for closing out a discrepancy accurately.

Trained direct care staff complete an inventory every shift of all the controlled substances. This is completed by two staff members and is documented on the youth's Medication Oversight and Inventory Record. A perpetual inventory is maintained on the youth's medication record each time a medication is given. Non-controlled medications are inventoried by maintaining a perpetual inventory each time it is given and inventoried one time each week. Over-the-counter medications and razors are inventoried by maintaining a running, perpetual inventory. From December 2018 until April 2019 OTC's and razors were not being inventoried weekly. During the week of the review the program had begun inventorying these weekly again.

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. There was no thermometer in the refrigerator to verify the temperature was between 36 – 46 degrees Fahrenheit.

Since the agency does not currently have an RN there are no weekly or monthly reports being consistently reviewed from the Knowledge Portal.

There were four files reviewed of youth in the shelter currently taking medications. A Medication Schedule Overview form was located in each file. This form documents all medications the youth is on, the times the medications are to be given, a picture of the youth, all alerts the youth is on, and the form is signed by the person completing it then reviewed by a supervisor. In all four files there was a Medication Oversight and Inventory Record form for each medication the youth was prescribed. This form documents the youth's name, date of birth, medication, strength, prescription number, pharmacy, date received, expiration date, beginning count, physicians name, reason of medication, and instructions for use. Each time the medication is given the date, time, start count, amount given, end count, youth initials, and staff initials are all documented. All inventories of the medications were also documented on this form. All the forms were signed by the staff initially completing them and then reviewed by a supervisor. All Medication Oversight and Inventory Record forms reviewed were filled out completely and

documented the youth received all prescribed medications within required time frames. There were printouts from Drugs.com for each medication the youth was taking, documenting important information, what happens if a dose is missed, what happens if an overdose, and side effects. All medications were verified by the staff calling the pharmacy. This was documented in the chronological notes in each file. Anytime a medication was given or inventoried it was also documented in the program's electronic logbook. On each shift there is one staff identified on the schedule as being responsible for dispensing medications for that shift. That staff is responsible for knowing which youth receive medications and then ensuring those medications are dispensed on time.

At the time of the on-site review the program did not have a Registered Nurse.

Inventories of over-the-counter medications and sharps were not completed weekly from December 2018 through March 2019.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has policy in place titled Medical to address the requirements of this indicator. The policy was last reviewed in April 2019 by the Chief Operating Officer.

To ensure all staff are informed about the specific medical needs of a youth, a Hot Dot alert system will be used. This will alert staff to which youth require special monitoring or precautions based on their specific mental health/medical needs. The Red dots signify a major health issue, the Yellow dots signify allergies, Green dots signify a mental health/behavioral issue, Orange dots signify sexual behavior concerns, White dots signify single room only, and the Blue and Pink dots alert staff the youth is on medication.

There were five youth files reviewed to verify the shelters alert system. All five files documented screenings and assessments were completed on the youth and any alerts identified were entered into the shelters alert system. The applicable alert and the reason for the alert were documented on the Intake and Assessment form. The youth had all the appropriate color-coded dots on the spine of the youth's file to indicate all alerts the youth was on. All alerts were also documented in a chronological note in each file, as well as, in the shelter's electronic logbook on the day the youth was admitted. All alerts were also documented on the Medication Schedule Overview form.

There were no exceptions to this indicator.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in titled Medical that addresses the requirements of this indicator. The policy was last reviewed in April 2019 by the Chief Executive Officer.

The program requires all staff who have contact with clients to receive CPR and First Aid training within the first 120 days of hire. In the event that a client receives first aid on-site or off-site an incident report is to be completed internally. Verification of medical clearance via discharge instructions and follow-up are to be present in the client file. Parent or guardian notification must be recorded and notation is the daily log book is required.

All but one staff have current training in CPR and First Aid. There are first aid kits located in the shelter and the vehicles. There was documentation that each kit was checked and inventoried monthly. Each vehicle is also equipped with a seatbelt cutter, window punch, and fire extinguisher. The knife-for-life and wire cutters are located in a cabinet behind the staff work area in the shelter.

The shelter has not had any off-site emergency medical incidents in the last six months. However, they have completed a mock emergency medical drill each month for the last six months. Each month the drill was completed on a different shift. The drills consisted of fights, a seizure, slip and fall, choking, and being injured while playing outside.

There were no exceptions to this indicator.