



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

Review of CDS-Interface NW

on 06/11/2019

**Compliance Monitoring Services Provided by**



## 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/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 SOGIE	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	Limited
3.07 Special Populations	Satisfactory
3.08 Video Surveillance System	Satisfactory

Percent of indicators rated Satisfactory: 87.5%  
 Percent of indicators rated Limited: 12.5%  
 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: 96.42%**  
**Percent of indicators rated Limited:3.57%**  
**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.
Not Applicable	Does not apply.

## Review Team

### Members

Marcia Tavares, Lead Reviewer/Consultant, Forefront LLC

Gina Dozier, COO, Capital City Youth Shelter

Brian Dye, Residential Services Manager

Katina Horner, Regional Monitor, Department of Juvenile Justice

Kelley Scott, Nonresidential Supervisor, Youth and Family Alternative

## Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, and (3) Shelter Care/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2018).

### Persons Interviewed

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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Chief Executive Officer<br><input type="checkbox"/> Chief Financial Officer<br><input checked="" type="checkbox"/> Program Coordinator<br><input type="checkbox"/> Direct – Part time<br><input type="checkbox"/> Volunteer<br><input checked="" type="checkbox"/> Clinical Director<br><input type="checkbox"/> Counselor Non-Licensed<br><input type="checkbox"/> Advocate<br><input type="checkbox"/> Nurse – Full time | <input type="checkbox"/> Executive Director<br><input checked="" type="checkbox"/> Program Director<br><input checked="" type="checkbox"/> Direct – Care Full time<br><input type="checkbox"/> Direct – Care On-Call<br><input type="checkbox"/> Intern<br><input type="checkbox"/> Counselor Licensed<br><input checked="" type="checkbox"/> Case Manager<br><input checked="" type="checkbox"/> Human Resources<br><input checked="" type="checkbox"/> Nurse – Part time | <input checked="" type="checkbox"/> Chief Operating Officer<br><input checked="" type="checkbox"/> Program Manager<br><b>1</b> # Case Managers<br><b>1</b> # Program Supervisors<br>___ # Food Service Personnel<br><b>1</b> # Healthcare Staff<br>___ # Maintenance Personnel<br>___ # Other (listed by title): ___ |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

### Documents Reviewed

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Accreditation Reports<br><input checked="" type="checkbox"/> Affidavit of Good Moral Character<br><input checked="" type="checkbox"/> CCC Reports<br><input checked="" type="checkbox"/> Logbooks<br><input checked="" type="checkbox"/> Continuity of Operation Plan<br><input type="checkbox"/> Contract Monitoring Reports<br><input type="checkbox"/> Contract Scope of Services<br><input checked="" type="checkbox"/> Egress Plans<br><input checked="" type="checkbox"/> Fire Inspection Report<br><input type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Table of Organization<br><input checked="" type="checkbox"/> Fire Prevention Plan<br><input checked="" type="checkbox"/> Grievance Process/Records<br><input type="checkbox"/> Key Control Log<br><input checked="" type="checkbox"/> Fire Drill Log<br><input checked="" type="checkbox"/> Medical and Mental Health Alerts<br><input checked="" type="checkbox"/> Precautionary Observation Logs<br><input checked="" type="checkbox"/> Program Schedules<br><input checked="" type="checkbox"/> Supplemental Contracts<br><input type="checkbox"/> Telephone Logs | <input type="checkbox"/> Vehicle Inspection Reports<br><input type="checkbox"/> Visitation Logs<br><input checked="" type="checkbox"/> Youth Handbook<br><b>3</b> # Health Records<br><b>3</b> # MH/SA Records<br><b>7</b> # Personnel /Volunteer Records<br><b>7</b> # Training Records<br><b>9</b> # Youth Records (Closed)<br><b>9</b> # Youth Records (Open)<br>___ # Other: ___ |
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### Surveys

**3** # Youth                                      **3** # Direct Care Staff                                      **0** # Other: \_\_\_

### Observations During Review

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

Additional Comments regarding observations, other important findings of interest, etc.

## Strengths and Innovative Approaches

### Rating Narrative

CDS Family and Behavioral Health Services, Inc. – Interface Youth Program Northwest (CDS-NW) provides both residential and non-residential services. This program site is located at 1884 Southwest Grandview Street in Lake City, Florida. CDS-NW provides services through a direct local service provider contract with the Florida Network of Youth and Family Services (FNYFS). The CDS-NW agency primarily provides CINS/FINS services in Columbia, Dixie, Hamilton, Lafayette and Suwannee Counties. CDS also operates other Residential and Non-Residential programs in Gainesville and Palatka, Florida respectively. All three program locations report to the agency's Chief Executive Officer and Chief Operations Officer that are located in the central office in Gainesville, Florida.

Since the last review period in April 2018, a lot of changes have taken place in the NW Region. The SNAP Program kicked off in October 2018 and the program was able to meet its contract deliverables for both SNAP Clinical and SNAP in Schools including providing service to an additional school for SNAP IN Schools at the school district request.

There have been a number of personnel changes in the NW Region. Unfortunately, the residential program has struggled with direct care staff turnover for various reasons; nevertheless, the program has continued its pursuit to find and hire qualified persons. After twenty years of service, Sr. YCW Johnnie Kelly retired in June of 2018 and Wanda Jones was promoted to the position. The entire midnight team has been replaced. The former residential counselor left and the position was replaced at the end of August 2018. Lastly, the Hamilton County non-residential counselor was also replaced during the current review period.

In an effort to address the total youth, IYP-NW has added yoga and meditation to its program. The yoga instructor comes two times a week and conducts two 45 minute sessions per visit with our male and female participants. The sessions focus on the importance of physical awareness, breathing and relaxation in relation to their importance during uncomfortable and challenging situations in life. Furthermore, the partnership with Columbia County School District has increased; as a result of the partnership, the program is provided two tutors Monday through Friday throughout the school year as well as during school breaks to address academic needs along with facilitating fun activities.

Dixie County and Columbia County Truancy Judges reached out to the agency to build a stronger partnership to address an ever increasing truancy problem in their respective counties.

Finally, through Challenge Grant funding the program was able to address many repair and maintenance issues including the replacement of flooring throughout the facility, replacement of old and worn seating and exterior painting.

## **Standard 1: Management Accountability**

### **Overview**

#### **Narrative**

The CDS-NW in Lake City, Florida location is operated by a Regional Coordinator. The Regional Coordinator position is the highest-ranking position for the agency at this location. The agency assigns the daily operation and direct responsibility of each shelter to a Residential Supervisor. The shelter also employs a Senior Youth Care Worker, 9.5 FTE Youth Care Workers, an Administrative Assistant, a Registered Nurse, and 2 Residential Counselors. In addition, the program has licensed Mental Health Clinician (LMHC) on staff who works as a Nonresidential Counselor but is also responsible for all clinical supervision of non-licensed staff.

The CDS-NW program agency conducts background screenings prior to hiring of all staff members. All staff members receive training at their respective service locations based on an Annual Training Plan that ensures all employees receive pre-service and ongoing training from the program's designated trainer, local providers, and the Florida Network. In addition, the agency consolidates trainings to simultaneously train its staff on various training topics across all work sites and to create better camaraderie amongst staff members assigned to various youth shelter locations. Each employee has a separate training file that contains a training plan and corroborating documentation for training received. Annual training is tracked according to the employee's date of hire.

CDS-NW maintains valuable inter-agency agreements with several agencies that ensure a continuum of services for the youth and families. The program has a strong outreach component, with participation of all program staff, with emphasis on areas designated as high crime zip codes. Community based staff provide services throughout the counties and schools served.

During the QI review, it was observed that the agency's policies and procedures do not have individual signatures of approval, just policy numbers and review/revision dates. The agency's policy is to review all policies and procedures on an annual basis and issue a memo letter indicating annual review of the CINS/FINS Operations and Procedures Manual. On January 4, 2019 a said memo was issued and signed by the Chief Operations Officer for the CINS/FINS Procedures Manual.

## 1.01 Background Screening

Satisfactory

Limited

Failed

### Rating Narrative

The agency has established policy P-1025 to address background screening requirements. The policy titled Background Check, Reference Check, Fingerprinting for Personnel, Volunteers or Interns was last revised in November 2016 and approved by Chief Operating Officer on January 4, 2019. The policy and procedure reviewed did not address the submission of the Annual Affidavit of Compliance with Level 2 Screening Standards prior to January 31<sup>st</sup> each year.

The agency's procedure clearly outlines the protocol for the completion of the Background Screening packet to determine the applicant's eligibility for hire and completion of the Livescan process. Request for screening is initiated through online clearinghouse portal. Background screenings will be processed and housed in the Care Provider Background Screening Clearinghouse online portal. Screening results will be displayed on the Clearinghouse website within three to seven days from when DJJ BSU receives the packet and fingerprint data. No offer of employment or volunteer/internship may be made prior to receipt of DJJ clearance. Five-year re-screens are conducted on employees, calculated from the "Retained Prints Expiration Date" posted on the Clearinghouse site. The HR Manager will initiate a resubmission and send the required documents to the BSU.

The agency has utilized two different pre-employment assessment tools since the beginning of the fiscal year: Predictive Index and HireSelect by Criteria Corporation. Management made the decision to adopt the latter of the two tools. HireSelect uses data-driven insights to predict hiring success. The Employee Personality Profile (EPP) is a general personality inventory that measures twelve personality traits that provide valuable insights into a person's work style and behavior. The EPP takes about 15 minutes to complete, and measures the following traits: Achievement, Assertiveness, Competitiveness, Conscientiousness, Cooperativeness, Extroversion, Managerial, Motivation, Openness, Patience, Self-Confidence, and Stress Tolerance. The report includes a results summary that includes detail, interview guide, and notes sections as well as an overall score.

There were a total of six staff hired since the last review. All six staff received a background screening prior to their hire date. There was one staff eligible for a five-year screening. The re-screening was completed prior to the staff's 5-year anniversary date, as required. The program did not have any current volunteers/interns but is in currently processing two interns who will start during the next fiscal year.

Predictive Index was utilized prior to the employment of two applicable candidates between October and December 2018 and HireSelect was implemented prior to hiring three applicable candidates in February 2019. Two of the three staff were pre-assessed and received overall ratings in excess of 70% which is an accepted criterion for the job. A pre-assessment screening was not observed for one of the three staff hired (DOH 2/11/19) after the implementation of the HireSelect tool. As of the date of the QI visit, the agency had not developed specific procedures for use of its pre-assessment tool including the type of assessment that is used, specific protocol followed, and suitability criteria/pass rate used to select candidates.

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The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Background Screening Unit on January 7, 2019.

**Exception:**

No exceptions were noted for this indicator.

**1.02 Provision of an Abuse Free Environment**

Satisfactory

Limited

Failed

Rating Narrative

The program has several separate policies that, in combination, address the elements of the indicator and outline how the program creates an environment where youth, staff and others can feel safe and free from threat of abuse or harassment. These policies include P-1044 Florida Abuse Reporting (which includes a quick reference guide), P-1032 Behavioral Expectations for Staff, P-1105 Complaint/ Grievance Process for Participants or Companions with Disabilities, P-1128 Rule Violations, and P-1212 Standards of Conduct. Review of the policies was last completed in January 2019 as indicated by a cover sheet for the Policies and Procedures manual which was signed by the Chief Operating Officer.

Youth and staff have unimpeded access to call the Florida Abuse Hotline– interpreted as allowing youth and staff to make decision to report allegations of abuse without obtaining permission. Staff may call or fax reports to the hotline and the numbers for both are posted / accessible. Reports are documented on the Florida Abuse Hotline Fax Transmittal Form. The form should be maintained in the participant record, along with a progress note as documentation of the event and reporting. A copy of completed Fax transmittal form is forwarded to the supervisor and COO and a copy is maintained in the Unusual Event Report file.

Similarly, youth may file a grievance by completing the reporter / participant section of the CDS Complaint / Grievance Report Form. The form is dropped in the Complaint /Grievance Box or given to the client's primary counselor. The client is then given a Complaint/ Grievance Report Receipt. If the grievance is against a staff member, the staff member does not address the grievance, but reports it to a supervisor. The primary counselor will work on a resolution for the complaint / grievance and if unable to provide a resolution, the grievance is presented up the chain of command until a resolution is reached. Each step / level of the process is to be addressed within 72 hours. When resolution is determined, it is documented and the client/participant is given the opportunity to sign acknowledging that the written resolution was received. There is a tracking process that includes maintenance of a file of all complaints/ grievances for at least one year.

Staff training records that reflected staff training on abuse reporting. The Unusual Events Report binder included documentation of at least five (5) child abuse reports made (including some follow-up /second reports) during the past six months.

Blank grievance form were observed to be available to youth in the living room/ day room areas of the shelter as well as the process for filing a grievance being posted on the clients information board. The Grievances Log (binder) was reviewed. There was only grievance on file for the past year. It was resolved as indicated by youth and counselor signatures on the same day it was submitted. It was signed reviewed and signed by a supervisor the following day.

Three youth were surveyed with all three indicating they know about the abuse reporting process and knew where the abuse registry number was located. None of the them said that had made an attempt to call the registry and all three indicated that



Similarly, two of the three indicated they were aware of the grievance process. All three youth has signed acknowledgment that they had been informed about how to file a grievance. All three youth indicated on the survey that the adults at the program are respectful and the youth had not heard staff use profanity.

**Exception:**

No exceptions were noted for this indicator.

**1.03 Incident Reporting**

Satisfactory

Limited

Failed

Rating Narrative

The program has two policies that address incident reporting. They are P-1045 Incident Report Procedures and P-1051 Unusual Event Report – Internal. The policies were last approved by the COO in January, 2019.

The focus of the policies is to ensure that unusual incidents/events are reported as required not only internally but to the Abuse Hotline and the Central Communications Center (CCC) as well as to ensure consistency in reporting. Situations involving occurrences or happenings that are outside the realm of normal/typical daily operations are recorded on an Unusual Event Report – Internal form. Unusual Event Reports are maintained in a binder.

The incident report binder was reviewed for the last six months. During that time frame there were four (4) incidents that were reported to the Central Communications Center (CCC). The notifications to the CCC were all completed within the required 2 hour time frame. Follow up communication with the CCC to respond to questions sent from the CCC was documented on two of the four incidents. For the other two incidents, the program called back to the CCC and updated them later the same date of the original report and there was, therefore, no additional information requested. There were also copies of fax cover sheets showing that the reports had been forwarded to the COO per policy.

There were a total of 27 internal unusual events noted during the last six month period. There was one incident identified as reportable that was not reported to CCC. Upon notification, the Regional Coordinator made a call to the CCC.

**Exception:**

There was an incident report found for an incident involving a vehicle crash on 5/16/19 that was not reported to the CCC. The Unusual Event Report - Internal form was marked "no" for possible DJJ reportable incident. The Regional Coordinator made a call to the CCC while during the review and the report was accepted and an incident report number assigned.

**1.04 Training Requirements**

Satisfactory

Limited

Failed

Rating Narrative

The program has an annual training plan that aligns with the fiscal year (July 2018- June 2019), which is how the agency tracks employee training hours.

The plan outlines training requirements for staff which mirror the requirements of the indicator for training to be completed within the first 120 days of hire, within the first year of employment, and

topics that are to be completed in the DJJ Skill Pro Learning Management System. The program's training plan indicates that Ethics: Civil Rights, EEO and Sexual Harassment are to be completed within the first 120 days, though these are not listed with that shorter time frame in the indicator.

A total of seven (7) training files were reviewed. Three (3) were examined to assess first year training requirements, three (3) for annual / beyond first year requirements, and one (1) for training on assessment of suicide risk for non-licensed Mental Health Clinical Shelter Staff. The second clinical staff training file was not applicable as the employee had been hired prior to 2014 when the specific training requirement documentation was implemented.

The training records were very neatly organized with an individual record for each employee in a classification folder with multiple sections. The first section was the current year training listings that included the date of training, the topic covered, the trainer/training source, and the number of hours. Certificates, sign in sheets, post-tests, etc. were located behind the list of completed trainings. Section 2 contains a copy of the program's training plan for the fiscal year, while Section 3 contains a more detailed plan of required trainings that indicates the training topic, for whom the training is designed/targeted (for example, all staff, residential staff ,etc.) which trainings are conducted at hire, which are conducted yearly, and the training materials available. The last section contained previous years' training records (if applicable).

A review of first year training revealed that two of three (2/3) staff are still within the first year and one had completed a full year of employment. The two who were still within the first year had 56.5 and 65 hours respectively. The other employee met the required number of hours for the first year with 89.5. All three staff had met the requirements for training required within the first 120 days, with a few exceptions. The direct care staff who were within the first year did not yet have documentation of several of the Skill Pro required trainings such Information Security Awareness, Equal Employment Opportunity, PREA, Sexual Harassment, Trauma Informed Care, Suicide Prevention and Human Trafficking 101. The reviewer did find that there were six (6) instances of the training in particular topics being completed, but not specifically in Skill Pro as required. One employee had Suicide Prevention Part 1 in Skill Pro 5/30/18, Part 2 in Skill Pro on 5/13/19 and had other in house suicide trainings on 9/1/18, 9/5/18, and 2/1/19. Another had Suicide Prevention- General and Suicide Prevention- Residential on 1/4/19 via the FNYFS training website, not via Skill Pro. This employee also had Human Trafficking 101 in Skill Pro 5/29/18 Sex Trafficking Solutions 1/4/19 via FNYFS website. A third employee had Suicide Prevention 1 via Skill Pro 5/29/18 and Suicide Prevention- Residential via FNYFS website 1/6/19. This staff member also had Sex Trafficking Solutions via the FNYFS website 1/6/19 but not the Human Trafficking 101 via Skill Pro.

For ongoing training beyond the first year, all three files reviewed had documentation of hours in excess of the number required hours (61.5, 42.5 and 45.5 for current year, respectively). All three had documentation of refresher training in Suicide Prevention, CPR and First Aid (all current), Fire Safety, PREA, Sexual Harassment, and Human Trafficking.

### **Exceptions:**

Two of the three (2/3) first year staff did not complete Managing Aggressive Behavior training. One did not have documentation of Behavior Management training that, as explained by the Regional Coordinator, is typically provide in a 1:1 setting as part of the employee's orientation process. The Regional Coordinator also explained that there was a challenge with having a

qualified and available MAB trainer for part of the review period. At the time of the review, the program had a trainer and a MAB class was scheduled for the upcoming weeks.

A deficit was noted for the documentation of training required for clinical staff in that the required form Documentation of Non-licensed Mental Health Clinical Staff Peron's Training in Assessment of Suicide Risk was not presented. The form was reportedly completed by the licensed clinician on staff for the Residential Counselor's determination of competency. However, the licensed clinician was on vacation at the time of the review and the form was not in the Counselors training record.

### 1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

#### Rating Narrative

The agency's policy P-1180 entitled Quality Assurance Program was last revised in August 2015. P-1180 addresses the agency's requirement for collecting and analyzing data specific to for the purpose of quality improvement. The agency also has a Risk Management Plan, P-1049 that was last revised in August 2015. The Program Improvement Plan policy P-1102 addresses the collection of feedback/input from a variety of sources including program participants. P-1102 was last revised in March 2009. All of the above policies were approved by the COO January 4, 2019.

The program collects and reviews data from several different sources of information to identify patterns and trends. Utilization reviews are conducted quarterly to ensure the appropriateness of services and patterns of utilization. The goal is to monitor and review all program records to assess compliance with contractual requirements. Random reviews of charts are conducted weekly by the coordinator or supervisor. Deficiencies are noted on service tally sheets and returned to the counselor/case manager with target dates or corrections and follow up review.

All program coordinators shall participate in the risk management program by identifying potential and actual risk situations arising from grievances/complaints, abuse reports, incidents, accidents, and unusual events. On a monthly basis, the coordinator or designee shall review all reports or patterns and trends prior to completing the Monthly Program Data Collection form. The coordinator may include a review of reports during staff meetings and note recommendations in the meeting minutes.

The Program Improvement Plan procedures include the identification of areas needing improvement as a result of reviewing consumer surveys and additional data collected from various consumers. Monthly, the data manager shall provide a report on the areas identified and progress towards the accomplishment of the goals.

The Data Systems Manager ensures that the quality assurance program is implemented in accordance with funding agencies. The process includes the tracking of performance measures, providing a system for analyzing those measures, reporting the results, and incorporating best practice models. Netmis data reports are also reviewed by the Data Systems Manager for monitoring contractual compliance.

The Regional Coordinator maintains a Peer File Review binder that contains quarterly file review done for each counselor. Peer reviews are documented on the Participant/Peer Review CINS/FINS form for each file reviewed. Documentation of peer reviews for the last two quarters was reviewed. A case selection of 3-5 records per counselor is done randomly each quarter.

The program completes a monthly report, which also becomes a semi-annual and yearly cumulative report, as it builds throughout the year which is called the CDS Performance and Risk Management Report. This allows staff not to only look at the monthly trends but how the data compares to prior months. A description and action taken for each report is also documented. The report includes: performance analysis and outcomes data; NetMIS data review; utilization data; and a review of incidents, accidents, abuse reports, and grievances. A copy of the Performance and Risk Management Report for the current FY 2018-2019 was obtained and reviewed. At the end of the FY, an annual Performance and Risk Management Report is generated with a cumulative report, graphs, and analysis for the entire FY. The annual review includes participant satisfaction results, per agency location, noting counts, results, and comments. A copy of the FY 2017-2018 Performance and Risk Management Report demonstrated compliance with the annual data collection and reporting by the agency.

The program holds monthly management meetings that are well documented with attendees and extensive agendas that include discussions and review of data and reports compiled during the periods. Staff meeting minutes demonstrate communication of trends and outcomes to staff on a regular basis.

**Exception:**

There were no exceptions to this indicator.

**1.06 Client Transportation**

Satisfactory

Limited

Failed

Rating Narrative

The program's *Vehicle Use and Safety Information* policy (P-1013) was last reviewed and approved by the COO in January 2019.

The policy addresses client transportation and indicates that to determine driver eligibility a driving history is obtained on each employee at the time of hire and annually thereafter within the month of the anniversary of their initial employment. Only administration approved employees may use CDS vehicles and/or drive participants in personal vehicles. The policy further articulates that best practice is to have a third party present in the vehicle while transporting a participant. A third party may be an approved volunteer, intern, agency staff, or other participant. The CINS/FINS Travel Log allows for documentation of the destination/purpose of travel, mileage, the name of the driver and other adult, the number of clients/ participants, departure and return times. Additionally, the form has a space to indicate whether the travel involves a single transport or not, and there is a space to record the approving supervisor, date and time of approval if applicable. Names of youth being transported are also documented in the Program Log book as leaving/returning.

The Van Mileage Log was reviewed for the last six months period. The travel log form has been revised since the last review and provides clear documentation of the elements. There was consistent documentation of single transports and evidence the supervisor signs and approves this the single transport in advance in a weekly log. There are multiple youth names listed for each week and the supervisor signs approving all those youth for single client transports for that week. The travel logs coincided with the documentation in the program Log Book. Twenty – two (22) random dates were reviewed and compared with only supervisory approvals. Overall, the practice appeared to be in accordance with the QI indicator requirements.

**Exception:**

There were no exceptions to this indicator.

**1.07 Outreach Services**

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedure which addresses all key elements of CQI indicators P-1050 and P-1053. The policy was updated and approved by the Chief Operating Officer on January 4, 2019.

The program's procedures requires designated staff at the program to provide services designed to increase public awareness of the needs of troubled youth at risk of running away, being habitually truant, or being beyond the control of their parents and guardian. The program will participate in local boards and council meetings to advocate for effective use of CINS/FINS services.

The program and multiple community outreach services on a consistent basis. The program has a binder in which they keep the meeting agendas from Circuit 13 Juvenile Justice Advisory Board Meetings. Based on the documentation in the binder, staff participated in local juvenile justice advisory board meetings during the review period when they were held. Documentation of the program's participation from each event included minutes, agendas, handouts, and power point presentations.

The program has cooperative service agreements with the University of Florida, law enforcement agencies, delinquency agencies, dependent agencies, schools, cultural arts, crisis stabilization units, shelters, career counseling centers, mental health and substance abuse counseling providers from several surrounding counties in circuits 3, 4, 5, 7, & 8. The program maintains written agreements with all community partners, which include services to be provided and a comprehensive referral process. Additionally, the program participates in a monthly performance meeting with their corporate staff to track risk management trends, utilization, and outcomes.

**Exception:**

There were no exceptions to this indicator.

## **Standard 2: Intervention and Case Management**

### **Overview**

#### **Rating Narrative**

The program provides counseling and case management services via their Interface Residential Program as well as the Family Action Non- Residential Program. Residential services are being provided by two Counselors and non-residential services are being provided by three Counselor/Case Managers, one whom is a Licensed Mental Health Clinician (LMHC). One of the three Counselor/Case Manager positions was vacant at the time of the review. The non-residential counselors provide services in the family's home, at a local community space, or in the counselor's office. All clinical staff and supervisors' interactions during the review demonstrated a solid understanding of program expectations and are conscientious about service delivery and meeting contractual standards.

The agency also leads and coordinates the local Case Staffing Committee, a statutorily-mandated committee that develops treatment plans for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court if needed.

The review of the youth records show that required documentation is in place all services are being provided to the youth and families in a timely manner by the counselors and case managers. For the purpose of this review, a total of 9 files were reviewed.

#### **2.01 Screening and Intake**

Satisfactory

Limited

Failed

#### **Rating Narrative**

Policy 1112 (Screening Process) was updated and approved by the Chief Operating Officer on January 4, 2019. This policy discusses the screening process within the agency. Policy 1115 (Intake Process) was updated and approved by the Chief Operating Officer on January 4, 2019.

The agency receives referrals through various resources such as family members of the youth, community agencies, truancy court, civil citations and the like. The screening process ensures that relevant information is obtained to identify a youth's immediate presenting issues and to determine eligibility. If it is determined that a youth is at risk of self-harm the screener is to contact 911 in order for youth to receive immediate emergency services. If a youth is determined to not present immediate danger, screening should proceed for relevant interventions. A referral and screening form should be considered for each youth entering Interface Residential or Family Action Non-Residential. Once a referral/screening has been completed the assigned counselor will then set an intake appointment with the youth and the family (non-residential program) to review the agencies services provided and practices as it relates to the program.

Residential referrals are screened and an intake is conducted the same day for placement.

Intake/Assessment process occurs after the screening process has determined eligibility for the youth. The intake/assessment process is to be initiated within 7 days of the screening. The intake/assessment of the youth may include but is not limited to the following: suicide risk screening, PAT (nonresidential youth), needs assessment, medical history and a suicide assessment of youth when necessary.

There were four non-residential files reviewed (two open and two closed) and three residential files reviewed (one open and two closed). All files reviewed contained screenings and intakes completed within the required time frame, all required paperwork covering agency practices (service options, rights and responsibilities, parent/guardian brochure, and grievance procedures) were reviewed and appropriate forms indicating the review and administering of required handouts was completed.

**Exception:**

There were no exceptions to this indicator.

**2.02 Needs Assessment**

Satisfactory

Limited

Failed

Rating Narrative

Policy 1019 discusses the needs assessment of the youth and was updated and approved by the Chief Operating Office on January 4, 2019. The purpose of this policy is to describe the intensive process of the needs assessment and to ensure this assessment is being conducted in a timely manner to address the youth's needs.

The agency conducts needs assessments with the youth that have been referred for services and meet eligible criteria. The needs assessment is utilized to assist the youth and their family in the development of the individual case plan to meet the specific presenting issues of the youth. The needs assessment is to be completed within 72 hours regarding youth in residential care. For non-residential care, the needs assessment is to be conducted within 2 or 3 face to face contacts with the youth upon the initial intake date.

The assessment is to be completed by a Bachelors or Masters Level staff member and then signed by the program supervisor or designee of the agency. If a suicide component is contained therein, the assessment must then be reviewed and signed by a licensed clinical supervisor or written by a licensed clinical staff.

There were four non-residential files reviewed (two open and two closed) and three residential files (one open and two closed). All files reviewed contained a suicide risk assessment of which there were no indicators of an elevated risk of suicide within any of the files. All files contained needs assessments signed by all participating parties including a supervisor review. All files contained needs assessments that described the youth's presenting issues which were then addressed in the individual service plan.

**Exception:**

There were no exceptions to this indicator.

### 2.03 Case/Service Plan

Satisfactory

Limited

Failed

#### Rating Narrative

Policy 1162 was updated and approved by the Chief Operating Office on January 4, 2019. This policy discusses the Individual Service Plans of the youth.

The Individual Service Plan is utilized to outline the youth's needs as identified in the initial screening and intake process and to offer interventions to address those needs. Individual Service Plan of the youth should be completed within 7 days of the completion of the needs assessment. The procedure of the agency describes in detail each element of the service plan. Elements include, type of service plan, frequency, location of services, parties responsible for executing the objectives of the plan and target dates of completion for components of the plan.

The service plans are to have documented target and completion dates and are to be signed by the youth and the parent/guardian. Individual service plans are to be reviewed every 30 days by the youth and parent/guardian during the first three months of service and then every 6 months going forward.

There were four non-residential files reviewed (two open and two closed) and three residential files reviewed (one open and two closed). All files reviewed contained an Individual Service Plan for each youth. All elements of the service plans examined were completed according to the policy and procedure of the agency. All plans were reviewed and signed by the youth, parent/guardian, counselor and supervisor. All plans met the required time frame of review.

#### **Exception:**

There were no exceptions to this indicator.

### 2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Policy 1163 discusses the coordination of services with other partnering agencies involved in the care of the youth and the family. This policy was updated and approved by the Chief Operating Office on January 4, 2019.

The policy ensures appropriate services are put into place as a result of the youth's needs identified in the assessment process. All contacts should be documented appropriately. Staff must ensure accurate documentation of all contacts with partnering agencies involved with the youth and the family. The agency also requires staff to follow up with youth after they are released from their individual programs at 30 and 60 day intervals.

There were four non-residential files reviewed (two open and two closed) and residential files reviewed (one open and two closed). Of the files reviewed, all met or exceeded the policy regarding proper documentation of continuity of care for the youth and the family. Documentation was also noted when the staff partnered with community resources for additional support of the youth and family.



Of the closed files reviewed all 3 applicable files had proper follow up documentation. The fourth closed file reviewed was recently closed and did not meet follow up criteria (recently closed June 8, 2019). The remaining three had documentation regarding 30 and 60 day follow up of youth. The agency's Administrative Assistant maintains a follow up binder containing all copies of follow ups relating to the youth completed each month.

**Exception:**

There are no exceptions to this indicator.

**2.05 Counseling Services**

Satisfactory                       Limited                       Failed

Rating Narrative

Policy 1046, Policy 1163 and Policy 1199 were updated and approved by the Chief Operating Officer on January 4, 2019. The policies discuss counseling of the youth based on the identified needs as described in the assessment process.

Counseling services are provided to the youth and family based on identified need and include individual, family, and group counseling 5 days a week (youth in shelter program). Services to the youth must adhere to the individual plan and thoroughly documented in the progress notes of the file. Internal reviews are completed monthly to ensure all indicator requirements are met.

There were 4 non-residential files reviewed (two open and two closed) and 3 residential files (one open and two closed). Of the files reviewed all were properly documented in accordance with the individual plan including frequency of service, target date and completed date.

Group counseling (shelter youth) includes but is not limited to: yoga, meditation, conflict resolution, healthy relations, social skills interaction, and managing anger. Group counseling was documented five days a week for youth in their files. For many group counseling offered the agency allows community representatives to come to the shelter and facilitate a group. A review of the supervision binder over the last six months indicates that monthly staffing/supervision meetings occur.

**Exception:**

There were no exceptions to this indicator.

**2.06 Adjudication/Petition Process**

Satisfactory                       Limited                       Failed

Rating Narrative

Policy 1157, Policy 1159 and Policy 1160 were updated and approved by the Chief Operating Officer on January 4, 2019.

The policies discuss case staffing committee meetings to ensure the committee is convened when a youth or family is in need of additional support services to obtain a successful outcome of the individual service plan. The agency is responsible to ensure a case staffing committee meeting is convened within seven (7) days (excluding weekends

and holidays) after the receipt of a written request from a parent/guardian of active CINS/FINS youth. The designated staff contacts all committee members, participants and/or guests. A copy of the letter is retained in the youth's file. Within seven days (7) following the case staffing committee meeting, a written report is provided to the parent/guardian outlining the reasons for the committee's recommendation for or against a petition being filed. As a result of the case staffing, youth and family may be provided a new or revised service plan. If parent is absent from staffing, a letter of recommendations is sent via mail within seven days.

There were two applicable case staffing committee meeting files reviewed of which they were open siblings. In the two cases the counselor initiated the case staffing request and the case staffing meeting was held within 7 days of being requested. All parents/guardian and committee members were notified no less than 5 working days prior to staffing. Case staffing committee members present included a local school district representative, DJJ representative, parents/guardian, mental health representative, substance abuse representative, DCF participants and law enforcement representative. The youth and family were provided a new or revised plan for services as a result of case staffing committee meeting. Documentation and parent signature on recommendations from staffing show that written reports are provided to the parent/guardian within (7) seven days of case staffing meeting.

The agency's Administrative Assistant maintained a Case Staffing Committee binder in which all committee member information, scheduled dates for the year of each committee meeting and proper email notifications to the committee members on upcoming meetings were documented.

**Exception:**

There were no exceptions to this indicator.

**2.07 Youth Records**

Satisfactory                       Limited                       Failed

Rating Narrative

Policy 1046 discusses the overall maintenance, security, and confidentiality of all youth files. The policy was updated and approved by the Chief Operating Office on January 4, 2019.

This policy ensures that all files are treated as confidential with limited access and staff understands the guidelines when working with confidential files. All files must be marked "confidential" and kept in a secure room or a locked filing cabinet. When files are in transport they are to be in an opaque container and the container is to be marked "confidential" as well.

There were four non-residential files reviewed for confidential markings, two case staffing files, as well as three residential files reviewed for confidential markings. All files reviewed had the appropriate "confidential" stamped in red on the front of each file. All files are kept under lock in key in a filing cabinet in a secure office with limited access. All files are transported when necessary in a black box or black rolling case with "confidential" in red on the front and with a lock on the box or case.

**Exception:**

There were no exceptions to this indicator.

**2.08 SOGIE**

Satisfactory

Limited

Failed

Rating Narrative

The agency implemented Sexual Orientation, Gender Identity, and Gender Expression (SOGIE) policy P-1284 effective September 2018 to ensure that all youth are provided a safe environment and therapeutic case planning regardless of the youth's actual or perceived sexual orientation, gender identity, or gender expression. P-1284 was approved by the COO on January 4, 2019.

Per the agency's procedures:

1. Youth are addressed according to their preferred name and gender pronouns.
2. Youth's preferred name and gender pronouns are used in the logbook and on all outward-facing documents and census boards.
3. All staff, service providers, and volunteers have knowledge of Florida Network policy #5.08 and the terms defined therein.
4. Youth in need of specialized support are referred to qualified resources.
5. Youth is not roomed in isolation due to sexual orientation, gender identity, or gender expression.

During tour of the facility, "Inclusion for Everyone" posters were posted in common areas such as the day room, youth dorm rooms, and in the calming room, indicating that all youth are welcome and should feel safe regardless of sexual orientation, gender identity, and gender expression. The program also has copies of the booklet "I Provide Safety Support and Respect" accessible for youth/families in the intake office along with a copy of their policy and procedures. The program did not serve any youth who met the criteria for the indicator; therefore, the reviewer was not able to assess practice with regards to youth preferences and case planning.

**Exception**

A review of staff training did not demonstrate all staff were trained and informed of the FN policies and procedures including policy 5.08. Only 1 of the 3 new staff training files reviewed included training in LGBTQ information.

The current agency's policy P-1284 does not address the requirements of Indicator 2.08 for item numbers 6-8 as follows: youth preference is considered and documented for room assignment; youth will be provided hygiene products, undergarments, and clothing that affirms their gender identity or gender expression; and the program will have signage placed in common areas indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression.

## **Standard 3: Shelter Care**

### **Overview**

#### **Rating Narrative**

The CDS-NW youth shelter is located in Lake City, Florida in Columbia County. The facility operates twenty-four hours per day, seven days per week and is licensed by the Department of Children and families for twelve beds. The agency serves both CINS/FINS and DCF program participants. At the time of the quality improvement review, there were a total of seven youth in the shelter. The shelter is comprised of a detached single building that has separate split floor plan design with female and male sides of the facility.

CDS-NW staff members are primarily responsible for completing all screening, intake and paperwork. These staff members are also responsible for orientation and providing necessary supervision and general assistance. The shelter's direct care staff members are trained to provide the following services including the youth screenings; medication administration; health, mental health and substance abuse screenings; first aid; cardio pulmonary resuscitation (CPR); and case specific referrals.

The supervisory and counseling staff members receive referrals and monitor service delivery on a consistent and on-going basis. The medication and first aid supplies are stored in the staff office in a locked desk behind a locked door near the dining/office area. The Direct Care Worker staff offices are located inside the youth shelter adjacent to the day room. The residential shelter also includes administrative offices for Regional Coordinators, Counselors and Case Managers, and the Administrative Specialist.

Residential services—including individual, family, and group services—are provided to youth and families. Case management and substance abuse prevention education are also offered. The program also has an effective grievance process. When submitted grievances are reported, they are generally addressed within seventy-two hours of being submitted to management.

#### **3.01 Shelter Environment**

Satisfactory

Limited

Failed

#### **Rating Narrative**

The shelter has a policy in place to ensure that the building is safe, secure and presentable to participants, families and visitors. The policy number is P-1210 and was reviewed by the COO on 1/4/19. All revisions and additions were approved by the COO in a memo that was signed by the COO on 1/4/19.

The policy ensures that the shelter environment shall be clean, neat, well maintained, safe, and to the extent possible, reflect a home-like environment. The procedures are well documented. Highlighted practices include regular inspections, cleaning and repairs, daily chores along with the documentation logs and corrective actions in addition to scheduling and faith-based activities. Specific procedures include discussion of the maintenance of office areas, bedroom and bathroom areas, laundry and linen area, living areas, kitchen and dining areas, public areas, grounds and pest control, and garbage disposal.

The program follows the requirements for annual fire and safety inspections as well as

completes the necessary fire and emergency drills. The grounds and facility are well maintained by the program. The youth are engaged in meaningful activities and the environment is safe and structured.

The shelter is a 12 bed facility located in Lake City, FL. The outside is well maintained as evidenced by landscaped and shrubs. All vehicle doors were locked and secured as well as the doors to the shelter. The shelter was graffiti free and furnishings were in great shape in appearance. There are egress plans posted throughout the shelter. The shelter's mission statement is also posted in several locations throughout the shelter along with grievance forms and the abuse hotline number. The daily schedules are posted in areas that are accessible to the participants and provide structured activities including 1 hour of physical activity as well as faith based activities and time for homework or quiet time to read. The shelter appeared to be insect and pest free. The shelter has a male dorm area and a female dorm area. Each dorm area has beds that were made up and neat in appearance. There was adequate space in the participants' rooms to do activities and the lighting was adequate. The bathrooms for the participants are located next to the dorms. They were clean and free from smells. There is living spaces for both males and females in their respective dorms. This area is for participants to have free time to read, play games etc. There is also a common area where both males and females congregate. The area has a real homey feel. There is adequate space to do activities such as watching movies, playing games and conducting groups. The participants have space to secure their belongings as well as their hygiene supplies.

The shelter completes 1 mock fire drill and 1 mock medical emergency drill per shift per quarter as evidenced by reviewing the emergency plans and disaster drill binder. The shelter's van was equipped with first aid kit, fire extinguisher and a multiuse tool that was a glass breaker, seat belt cutter and air bag deflator all in one. The shelter has current MSDS books that are in all areas where chemicals are stored. The menus for the participants' meals are located in the kitchen area which is accessible to the participants. The cold and dry food is stored properly and the spaces are clean and free of any unacceptable debris. Inspections and licensing - DCF child care license is good until March of 2020; annual fire inspection was done on 1/4/19 and shelter is in compliance; the alarm system inspection was done on 6/3/19; the fire suppression inspection was done on 4/22/19; Health Department did a satisfactory inspection on 2/1/19; and dietician's license is good until May 31 2021.

**Exception:**

There were no exceptions to this indicator.

**3.02 Program Orientation**

Satisfactory

Limited

Failed

Rating Narrative

The shelter has a policy in place that meets the requirements of the Florida Network's policy that ensures that orientation is done in a timely manner and is completed in its entirety. Policy numbers P-1114, P-1115 and P-1116 were reviewed by the COO on 1/4/19. All revisions and additions were approved by the COO in a memo that was signed by the COO on 1/4/19.

The shelter uses several forms to make sure the policy is followed according to the standards. Upon arrival the orientation process is explained by staff to the participant. The participant signs the informed consent and participation agreement and receives the orientation packet, which is theirs to refer to during their stay in shelter. The participant also signs the orientation checklist. There is also an informed consent and participation agreement that is explained to the parent/guardian and is signed by the parent and staff.

There were 3 charts (1 open and 2 closed) reviewed for this QI review. All 3 had the participation agreement signed by staff and the participant within the first 24 hours of the intake process. There is also a participant agreement signed by the participant's parent/guardian which is also in the participant's file. All three charts reviewed had acknowledgement from the youth of receiving a resident handbook, disciplinary action explained, grievance procedure explained, emergency/disaster procedures, contraband rules, physical facility layout map, room assignment and suicide prevention alert notification which is explained by staff.

**Exception:**

There were no exceptions to this indicator.

**3.03 Youth Room Assignment**

Satisfactory                       Limited                       Failed

Rating Narrative

The shelter has a policy in place to ensure that the participants sleeping arrangements are determined in order for the safety and security of the participant and to make staff aware of any issues. The policy also addresses any medical or mental health issues. The policy P-1116 was reviewed by the COO and was approved by COO in a memo that was signed by the COO on 1/4/19.

Upon admission into the program each youth is interviewed to determine what the most appropriate bed assignment/sleeping arrangements that need to be made to increase safety and staff awareness. This information is documented on the second page of the intake assessment in a box marked Participant Room Assignment. Some of the information gathered is age, gender, height, weight, religious affiliation, suicide risk, criminal offenses, assault or aggressive behaviors, medical history, mental health or substance use. Due to the dorm style arrangement of the shelter, youth are assigned beds and bunks based upon the assessment at intake.

There were 3 files (1 open and 2 closed) reviewed for this QI review. All 3 had the intake assessment form completed to ensure that the participant was assigned to the proper room according to answers provided by the participant. Room assignment is documented on page 2 of the intake form. The shelter has an alert system to advise staff of specific alerts both in the participant's file as well as on the alert board in the staffs office.

**Exception:**

No exceptions were noted for this indicator.

**3.04 Log Books**

Satisfactory                       Limited                       Failed

Rating Narrative

The shelter has a policy in place that meets the requirement of the indicator and ensures that written records of all events that occur are documented. P-1149 was reviewed by the COO and was approved in a memo that was signed by the COO on 1/4/19.

The log book is utilized each shift to document daily program activities and occurrences at the facility. Significant events and incidents are highlighted in the log book. Shift leaders review the

log book daily and provide oversight and instruction in the log book each shift. The facility utilizes a bound notebook that records the program activities on a shift by shift basis. The pages of the log book consist of key sections filled out by staff including staff on duty, Shift Leader Assignments, participant count, Shift Leader Review, Pass on Information Chronological Shift Events, Shift Leader Summary and Shift Leader Comments. The Shift Leader fills out the first sections with staff on duty and participant count at the beginning of the shift along with the previous dates and shifts reviewed. An excellent practice of documenting pass on information is completed next giving staff on duty important information about current or future shifts. The next part of the log book is the shift events that document daily occurrences. Finally the Shift Leader summarizes the events of the day/shift and makes comments based on events or needs.

The shelter's logbook for the time period of 2/15/19 to 3/2/19 was reviewed. The logbook entries were legible and written in ink with no notice of any whited out entries. All entries that were made in error had a single line through the error, the word error written above it and staffs initials. Most had dates that the error was made, some were missing this component. It was observed that safety and security issues were documented. Staff documented in the logbook at the beginning of each shift who was on shift and the participants that were presently in the shelter. The logbook showed that both staff and supervisors reviewed the logbook as required by the standard and review notes were highlighted. The logbook also had an area for information that need to be passed along. In interview with the shelter supervisor it was stated that if an incident happens an incident report is filled out and sent to the COO but it is not documented in the logbook.

**Exception:**

No exceptions were noted for this indicator.

**3.05 Behavior Management Strategies**

Satisfactory

Limited

Failed

Rating Narrative

The shelter has a policy in place that implements a behavior management system that meets the requirement by ensuring the participant comply with program rules and make positive choices to increase their accountability and responsibility. The policies P-1222, P-1123, P-1125, P-1126, P-1127 and P-1128 were approved by the COO in a memo that was signed by the COO on 1/4/19.

The behavior management system that the shelter uses is the FACE (Facilitating Activity & Communication Effectively) system. The program provides youth with a Facilitating Activity and Communication Effectively, "FACE BOOK," at orientation. The booklet outlines the behavior management system utilized by the program. This booklet contains general information about the behavior management system, program rules, point sheet guide, behavior expectations, program schedule, curriculum/social skills and the point sheets themselves. When a participant arrives in shelter they are oriented to the program rules, the response/consequences of violating the rules and the FACE system its self and then works with a counselor to determine meaningful individualized goals.

The behavior management system was reviewed onsite by interview with staff and observation of use with youth. The FACE system is comprised of 3 levels. The first level is the Assessment which is for 3 days and gives the participant the opportunity to become familiar with the

system. The 2nd level is Daily which is where youth are expected to understand the system and demonstrate appropriate behaviors. The 3rd level is Achievement where the participant has the opportunity to negotiate their points to obtain privileges for the next 24 hours. A Youth Care Worker was interviewed and was very knowledgeable about the system. The participant receives points throughout the day from staff if they meet their required behaviors on all 3 shifts. The points are added up at night and are discussed at the house meeting in the evening. The participants currently in shelter were also interviewed and they all agreed that the system was explained to them at orientation, the system was easy to understand, and that staff is consistent with how the system is operated, such as violations of rules or what points are assigned. The shelter does not use any form of seclusion or mechanical/material restraints to control the behaviors of the participants but instead use the training they have received to make sure aggression is addressed in manner to de-escalate and manage behaviors for a positive manner.

**Exception:**

No exceptions were noted for this indicator.

**3.06 Staffing and Youth Supervision**

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place that meets the requirement and ensures that the shelter is adequately staffed to supervise the participants as well as to ensure the safety of the participants and staff at all hours. Policies P-1121 and P-1133 were reviewed by the COO and approved in a memo that was signed by the COO on 1/4/19.

The regional coordinator or the designee is responsible for scheduling to ensure that all shifts are covered to meet the guidelines of staffing ratios of 1 staff to 6 participants during awake hours and community activities, 1 staff to 12 participants during the bedtime hours, and that there is at least a male and female on shift when the shelter has male and female participants. During the bedtime hours the staff is encouraged to work as a team to ensure that the standards are being met such as documentation of bed checks and that night time duties are completed.

The shelter has the staff schedule posted in the staff office accessible to all staff. There is protocol in place to ensure that there is coverage if staff calls in or if there is a vacancy on the schedule. The schedule indicates that the staffing ratio is met such that a minimum of 2 staff as well as male and female staff and are on each shift. This information is verified by documentation in the logbook. The bed checks are done by 2 methods. The shelter has hand held scanners. There are barcodes in the participants' rooms that are scanned and it is electronically entered into the shelter's system. Those reports can be printed off. If the scanners are not used then staff documents bed checks manually. There is a form that is filled out by staff when a check is done. For each bed check, the time is noted, what the participant was doing, and the staff's initials are documented. The staff doing the check then signs the bottom. Room check forms for 4/18/19, 5/1/19, 6/1/19 and 6/5/19 were randomly selected and reviewed. When the checks were compared to the video for those days it was observed that some of the checks documented and recorded as bed checks were not actually done.

Supervisory reviews were conducted as required and documentation was maintained in the Video Reviewed binder. Although it showed that videos were reviewed, the times were not randomly selected for the overnight shift. The two designated reviewers are the Regional Director and Shelter supervisor.



### Exception:

As a result of false documentation of bed checks observed by two different staff during the video reviews on the following random dates and overnight shifts: 4/18/19, 5/1/19, 6/1/19 & 6/5/19. One of the staff was observed to have falsified bed checks at least twice during the overnight shift on the four random dates observed; the other staff was observed to have falsified bed checks 4 times on one of the overnights. A CCC report was made and consequently accepted. The discovery of this occurred during the QI review on 6/11/19 at 1pm. CCC was called at 1:33 pm and the report was accepted. The report number is 201902451.

### 3.07 Special Populations

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has written policies in place (P-1248, P-1249, P-1267, P-1279, P-1282, and P-1283) addressing Special Populations. These policies address the necessary aspects of Indicator 3.07. The aforementioned policies related to Special Populations were approved in a memo that was signed by the COO on 1/4/19.

P-1248 Staff Secure Shelter Services indicates that in-depth orientation at admission, assessment and service planning, enhanced supervision and security, parental involvement, and a collaborative aftercare are all included in agency policy. P-1249 indicates that youth referred for Staff Secure Shelter must meet the eligibility requirements of Florida Statute 984.225, that each shift should have specific staff assigned to monitor the movement and location of staff secure youth at all times, and that assigned staff members are noted in the Program Log Book. P-1248 lists under Collaborative Aftercare that the agency will work with the court, parents, youth, and referring CINS/FINS provider to discuss follow up services. This process included transferring all pertinent documentation to the referring local provider.

P-1267 Domestic Violence Respite indicates that a youth eligible for domestic violence respite services must have a pending Domestic Violence (DV) charge, and be screened by the JAC/Detention or Screening Unit, but must not meet the criteria for secure detention. This same policy document states that DV services must not exceed twenty-one days. No specific procedure was listed related to the transfer of DV youth to CINS/FINS or Probation Respite placement. P-1267 indicates that the Individual Plan for DV respite youth should include: anger/aggression management, family coping skills, or other interventions designed to reduce propensity for violence in the home; and notes that services provided to DV respite youth should be consistent with all other CINS/FINS program requirements.

P-1279 indicates that Probation Respite youth shall be referred by DJJ Probation, must be on Probation with Adjudication Withheld, and must be approved by the Florida Network with a time of stay determined at the time of admission. Furthermore, this policy states that the length of stay should be anticipated for fourteen to thirty days with placements beyond thirty days requiring JPO, Chief Probation Officer, and Florida Network approval. Finally, this policy notes that services for these youth should be consistent with all other CINS/FINS program requirements.

P-1282 addresses Domestic Minor Sex Trafficking youth whose referrals must be approved by the Florida Network or a maximum of 7 days and entered into NetMIS as a special populations youth at admission. Approval for support beyond 7 days may be obtained on a case-by-case basis.

P-1283 addresses the criteria and services to youth who meet the criteria for Family/Youth Respite Aftercare Services (FYRAC) as follows: referral from DJJ or a DV arrest or probation regardless of adjudication status and at risk of violating; approval by the Florida Network; adherence of intake and case files to FN policy; and provision of intake/initial assessment session, life management sessions, individual sessions, and group sessions. However, the current FYRAC policy and procedures do not include all of the requirements with regards to the content of intake and initial assessment sessions and units of services required for life management sessions, individual sessions, group sessions, and required number of times youth and families participate.

The agency has not had any staff secure, probation respite, domestic minor sex trafficking, or FYRAC youth served within this review period. The agency has had three DV Respite youth served during this review period. The agency is not contracted to provide ICM services.

Three DV Respite files were reviewed. All three files included a Domestic Violence Respite Referral form showing that the youth were screened appropriately and had a length of stay that did not exceed twenty-one days. Consequently, none of the youth had to be transitioned to CINS/FINS. One applicable youth had an Individual Plan (case plan) that included aggression management, family coping skills, or other interventions to decrease domestic violence in the home. The length of stay for the other two youth was too brief (between 1 -2 days) and an individual plan could not be completed; however, an initial plan was implemented for all 3 youth with goals to follow all program rules and participate in the assessment process. All of the files reviewed were consistent with general CINS/FINS program requirements.

**Exception:**

No exceptions were noted for this indicator.

**3.08 Video Surveillance System**

Satisfactory

Limited

Failed

Rating Narrative

The shelter has a policy in place that meets the requirement for ensuring that there is video surveillance operating 24 hours a day, 7 days a week so the safety of all participants, staff and visitors is met. Policy P-1280 was reviewed by the COO and approved in a memo that was signed on 1/4/19.

The shelter shall maintain a video surveillance system that operates twenty-four hours a day, seven days a week to monitor and capture a recording of agency happenings. A written notice shall be conspicuously posted at the shelter entrance noting that cameras are in use for the purpose of security. The video surveillance system should only be accessible to staff trained to handle the equipment and is only accessible to designated personnel (a list is maintained which also includes off-site capability per personnel).

Supervisory reviews of the weekly activities on video is conducted bi-weekly and noted in the logbook. The reviews assess the activities of the facility and include a review of a random sample of overnight shifts. Review of any footage should be authorized by a supervisor and handled in a professional, ethical, and legal manner.

Cameras should be able to record date, time and location and maintain resolution that enables facial recognition. Cameras shall have back up capabilities that allow for operation during a

power outage. The shelter ensures that cameras are placed in the interior and exterior of the building and that they are visible to all participants, staff and visitors who are at the shelter. They also ensure that the cameras are not in the participants' bathrooms or their sleeping areas to maintain a level of privacy.

The shelter currently has 16 cameras (4 outside and 12 inside) that are functional and are not obstructed in any way. There is a sign in the lobby of the shelter informing participants, staff and visitors that there is video monitoring in progress. All cameras were visible and in the general areas where participants and staff congregate. No cameras were observed in the participants bedrooms nor were there any in the bathrooms. The system has the capability to record all activity with the location, date and time. The system has the capability to run on backup in case of a power outage. There is a binder that shows video reviews that are conducted at least once every 2 weeks. The cover of the binder lists who can do reviews either in house or remotely off site. The reviews were also noted in the shelter's logbook and were highlighted. The system stores/retains information for at least 30 days and info can be saved longer if requested for any type of investigation pertaining to any incidents.

**Exception:**

No exceptions were noted for this indicator.

## **Standard 4: Mental Health/Health Services**

### **Overview**

#### **Rating Narrative**

The CDS-NW program has specific procedures related to the admission, screening, interviewing, client inventory, and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. Upon admission, program staff will conduct a full intake interview with the youth and parent/guardian if available. Staff on duty at the time of admission immediately identifies youth that are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The Regional Coordinators and/or Licensed Clinicians are notified immediately if risks and alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. The shelter has one Counselor that is a Licensed Mental Health Clinician (LMHC).

The agency operates a detailed medication distribution system using the Pyxis Med-Station 4000 Medication Cabinet. The program has a Registered Nurse (RN) on-site seven days a week. The shelter has a list of staff members that are authorized to distribute medication. The facility is equipped with multiple first aid kits, knife for life and wire cutters. The staff are trained to provide CPR and First Aid services in case of an emergency. Staff members are also trained on fire safety techniques and various emergencies. As of the date of this onsite review, all fire safety equipment are up-to-date and functioning as required.

#### **4.01 Healthcare Admission Screening**

Satisfactory

Limited

Failed

#### **Rating Narrative**

The program has a written policy and procedure P-1117 and P-1118 which addresses all key elements of the CQI indicator. The policy was updated and approved by the Chief Operating Officer on January 4, 2019.

The program's procedures require a screening to be completed to identify the physical and mental health status of each youth on the day of admission by a nurse if on duty or reviewed by a nurse within five business days if not present during the intake. The information will be recorded on an Intake/Assessment Form and document any area of concern and/or need to follow up and initiate a medical/mental health alert.

Three youth files were reviewed, and each included a healthcare admission screening completed on the day of admission. The healthcare screening included all required elements and none of the youth required an emergency response or referral for follow up medical services related to a chronic condition. The program has procedures in place to document and follow up and/or referrals on a Medical Health Follow Up Form during the intake process.

#### **Exception:**

No exceptions were noted for this indicator.

## 4.02 Suicide Prevention

Satisfactory

Limited

Failed

### Rating Narrative

The program has a written policy and procedure P-1144 and P-1247 which addresses all key elements of CQI indicator. The policy was updated and approved by the Chief Operating Officer on January 4, 2019.

The program's procedures require an initial screening to be completed on the day of admission to identify any medical, mental health, substance abuse, or suicide risk factors of youth. If there is any indication of increased suicide risk, the youth must be placed on One-to-One or Constant Sight and Sound Supervision and a full suicide assessment must be completed. A mental health alert and youth safety agreement must also be initiated. The suicide assessment will be completed within 24 hours of the initial screening, unless the screening occurs outside of business hours on a Friday, in which case the assessment will be completed within 72 hours. If the youth is an immediate danger to themselves or others the youth will be placed on one-to-one supervision and staff will immediately call 911 and request assistance for law enforcement for a baker act. If at any time during the youth's stay in the shelter, the youth expresses any suicidal thoughts or ideations the youth is placed on constant sight and sound supervision until a full risk assessment is completed by a qualified staff.

The agency has two levels of supervision. One-to-one supervision is the most intense level and is used for youth waiting to be removed from the program by law enforcement for a baker act. One staff member, who must be the same gender as the youth, will remain within arm's length of the youth at all times. The second level of supervision, Constant Sight and Sound Supervision, is for youth who are identified as being high risk of suicide but are not expressing current suicidal thoughts or threats. A staff member must have continuous, unobstructed, and uninterrupted sight of the youth and be able to hear the youth. Staff assigned to monitor the youth must document his/her observations of the youth's behavior at intervals of thirty minutes or less for both one-to-one supervision and constant sight and sound supervision.

Three closed youth files were reviewed, and each included a suicide risk screening completed on the day of admission. The suicide screening results indicated suicide risks and were reviewed and signed by a supervisor and documented in the youth's case file for all three youth. All three youth were appropriately placed on sight and sound supervision until they were assessed by a non-licensed professional working under the supervision of a licensed mental health counselor (LMHC). The LMHC has a clear and active license which expires on 3/31/21 and there was no evidence of discipline, emergency action, or public complaints. Initiation of increased youth supervision levels were highlighted in the logbook and supervision of each youth was documented in 30-minute intervals or less on an Observation Log Form in all three cases. Mental Health alerts were placed on the outside of each youth's file. The supervision level was not changed or reduced until each youth was assessed by a mental health professional. The program's suicide risk assessment tool has been approved by the Florida Network of Youth and Family Services.

### **Exception:**

No exceptions were noted for this indicator.

### 4.03 Medications

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a written policy and procedure P-1120 which addresses all key elements of CQI indicator with the exception of epi-pen training. The policy was updated and approved by the Chief Operating Officer on January 4, 2019.

The program's procedures require youth medication to be received by a staff member directly from the participant's parent/guardian. Only medication from a licensed pharmacy with a current proper patient specific intact label on the original container may be accepted. The medication should be verified, counted, and documented on a Medication File Log. The program has a Pyxis Med-Station 4000 Cabinet to store all medication and it is inaccessible to youth. The program has two Super Users for the Med-Station. The program does not accept any youth with currently prescribed injectable medications except for epi-pens. During the time of the review there were no youth currently admitted with a prescribed epi-pen. All medication types are stored separately inside the Med-Station. While the program does not currently have any youth admitted taking prescribed medication requiring refrigeration, there is a refrigerator used only for this purpose maintained in a secure area inaccessible to youth. The nurse documents the refrigerator temperatures on a weekly basis. Logs from the past six months were reviewed and recorded temperatures were within an appropriate range. During the time of the review there were no youth taking controlled medication.

Three closed files were reviewed documented controlled medication inventories as required. The program's procedure is to complete shift-to-shift counts and maintain perpetual inventories with running balances of controlled medication. The program maintains a list of staff designated in writing who have access to secured medications and limited access to controlled substances. The program does not currently have any sharps on site and does not accept youth who are syringe dependent. There is a procedure in place to count epi-pens weekly and perpetually if used. The program does not keep over-the-counter medication on site. Assisted medication administration by staff is documented on a Medication Distribution Log. During the last six months the nurse completed weekly medication management practice reviews via Pyxis Med-Station Reports. The nurse verifies all medication by reviewing the prescription and consulting the pharmacy if needed. All medication processes are completed by the nurse when on duty. The program does not utilize a delivery service for medication. All youth medication is brought in by the parent/guardian. When applicable, medication discrepancies are cleared after each shift.

#### **Exception:**

The program accepts youth with prescribed epi-pens; however, there was no documentation of staff training on epi-pen use.

#### 4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

##### Rating Narrative

The program has a written policy and procedure P-1119 which addresses all key elements of the CQI indicator. The policy was updated and approved by the Chief Operating Officer on January 4, 2019.

The program's procedures require each youth receive a preliminary medical, mental health, suicide risk, and substance abuse screening on the day of admission. Any conditions will be noted on the Intake/Assessment Form. All youth medication will be documented on the Medication File Log as well as the Intake/Assessment Form. Medication allergies, food allergies and any other allergies will be noted on the Intake/Assessment Form, Medical File Log, and on the outside cover of the participant's file with either an "Allergy" or a "Medical/Mental Health Alert" label. Additionally, coded alerts will be noted on the participant board and documented in the program logbook.

Three active and three closed youth files were reviewed, and each had a medical and/or mental health condition. All six youth were appropriately placed on the program's alert system. The alert system includes precautions concerning prescribed medications, medical/mental health conditions. Staff are provided sufficient information/instructions to recognize/respond to the need for emergency care for medical/mental health problems. The program has a comprehensive medical and mental health alert system in place to ensure information concerning all youth medical conditions, allergies, side effects of medication, and mental health information is communicated to all staff using the alert board, alert tags on outside of youth files, and in the logbook.

##### **Exception:**

No exceptions were noted for this indicator.

#### 4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

##### Rating Narrative

The program has a written policy and procedure P-1166 which addresses all key elements of CQI indicator. The policy was updated and approved by the Chief Operating Officer on January 4, 2019.

The program's procedures are to maintain their own first aid kits and its supplies. First aid kits will be stored in areas on site and in vehicles accessible to staff. First aid kits at residential sites should be inventoried weekly, not include any expired contents, and be replenished as needed. A knife for life and wire cutters shall be maintained in a secure area of the program. All staff in direct continuous contact with youth must be certified in CPR and First Aid.

Three closed files were reviewed, and each received off site emergency care. An incident report was completed and submitted for each emergency medical incident. Upon each youth's return a medical clearance was documented via discharge instructions. The parent/guardian was notified in all three instances and a daily log is maintained. The knife-for-life and wire cutters are secured

in the nurse's office. The program has four first aid kits that are monitored for expired contents and replenishment weekly by the nurse. The kits are located in the nurse's office, kitchen, and both vehicles used to transport youth and staff. The program maintains a list of emergency contact numbers. Fourteen staff were trained on emergency procedures by the nurse.

**Exception:**

No exceptions were noted for this indicator.