



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

Review of LSF SW- Oasis

on 09/10/2014

## CINS/FINS Rating Profile

### Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Limited
1.05 Analyzing and Reporting Information	Satisfactory

Percent of indicators rated Satisfactory: 80.00%  
 Percent of indicators rated Limited: 20.00%  
 Percent of indicators rated Failed: 0.00%

### Standard 3: Shelter Care

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

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

### Standard 2: Intervention and Case Management

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

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

### Standard 4: Mental Health/Health Services

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

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

## Overall Rating Summary

Percent of indicators rated Satisfactory: 95.83%  
 Percent of indicators rated Limited: 4.17%  
 Percent of indicators rated Failed: 0.00%

### Rating Definitions

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

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

### Review Team

#### Members

Marcia Tavares, Lead Reviewer - Consultant Forefront LLC

Baldwin Davis, Chief Compliance Office, Miami Bridge Youth and Family Services

Paul Hatto, Shift Supervisor, Stewart-Marchman Act Corporation



**Quality Improvement Review**

LSF SW- Oasis - 09/10/2014

Lead Reviewer: Marcia Tavares

---

Shad Renick, Program Director, Sarasota YMCA

**Persons Interviewed**

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

**Documents Reviewed**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Accreditation Reports                        | <input checked="" type="checkbox"/> Fire Prevention Plan             | <input type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records        | <input type="checkbox"/> Visitation Logs            |
| <input checked="" type="checkbox"/> CCC Reports                       | <input type="checkbox"/> Key Control Log                             | <input checked="" type="checkbox"/> Youth Handbook  |
| <input type="checkbox"/> Confinement Reports                          | <input checked="" type="checkbox"/> Logbooks                         | 4 Health Records                                    |
| <input checked="" type="checkbox"/> Continuity of Operation Plan      | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 4 MH/SA Records                                     |
| <input checked="" type="checkbox"/> Contract Monitoring Reports       | <input type="checkbox"/> PAR Reports                                 | 26 Personnel Records                                |
| <input type="checkbox"/> Contract Scope of Services                   | <input checked="" type="checkbox"/> Precautionary Observation Logs   | 6 Training Records/CORE                             |
| <input checked="" type="checkbox"/> Egress Plans                      | <input checked="" type="checkbox"/> Program Schedules                | 3 Youth Records (Closed)                            |
| <input type="checkbox"/> Escape Notification/Logs                     | <input checked="" type="checkbox"/> Sick Call Logs                   | 6 Youth Records (Open)                              |
| <input type="checkbox"/> Exposure Control Plan                        | <input checked="" type="checkbox"/> Supplemental Contracts           | 0 Other   |
| <input checked="" type="checkbox"/> Fire Drill Log                    | <input checked="" type="checkbox"/> Table of Organization            |   |
| <input checked="" type="checkbox"/> Fire Inspection Report            | <input type="checkbox"/> Telephone Logs                              |   |

**Surveys**

- |         |                     |         |
|---------|---------------------|---------|
| 3 Youth | 3 Direct Care Staff | 3 Other |
|---------|---------------------|---------|

**Observations During Review**

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

**Comments**

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

Rating Narrative

## Strengths and Innovative Approaches

### Rating Narrative

Lutheran Services Florida (LSF) is a statewide, non-profit, human services agency dedicated to helping all people. Its headquarters is located in Tampa, Florida. The agency has more than 60 programs located throughout Florida. The Southwest program, Lutheran Services Florida Southwest (LSF SW), provides a variety of services for youth and families. LSF SW is the designated Residential and Non-residential CINS/FINS provider for Lee, Charlotte, Collier, Hendry, and Glades Counties. The Oasis Youth Shelter is the residential program located in Fort Myers, Florida.

In addition to providing CINS/FINS services, LSF SW is the Lead Case Management program in southwest Florida which is funded by the Florida Department of Children and Families, through the Children's Network, to provide Child Welfare services to children in Lee and Charlotte counties. Services provided under this contract include: protective supervision, foster care, and adoption services. LSF SW also provides Guardianship Services, providing protection to incapacitated individuals age 18 and over in DeSoto, Manatee, and Sarasota counties.

LSF was first accredited by the Council on Accreditation (COA) in 2004 and was recently re-accredited by COA through February 28, 2018. This consistent achievement demonstrates the organization's commitment to maintaining the highest level of standards and provision of quality services to its consumers.

LSF SW participates in the National Safe Place Program, a network of voluntary community sites such as Fire Stations, local businesses, and schools that partner with the agency to provide a safety net where youth in need of help can go for refuge. A designated staff is responsible for Safe Place site recruitment, training, and ongoing support as well as community and school presentations. The efforts of the program are evident by the more than 200 Safe Place signs displayed on county libraries, fire stations, and other prominent businesses in the region. Safe Place sites also include all Walgreens, Goodwill Stores, United Way Houses, and Lee County Transportation.

In addition to the collaboration with Safe Place sites, the program also has numerous interagency agreements that are used to network with the surrounding communities, such as low-performing schools, community parks, and various designated neighborhoods in an effort to make agencies, youth, and families aware that services are available to address the needs of troubled youth and families.

## Standard 1: Management Accountability

### Overview

#### Narrative

LSF SW operates both the Oasis Youth Shelter (residential) and Non-Residential CINS/FINS Program in Lee County, Florida and is the designated CINS/FINS provider for the surrounding counties namely Charlotte, Collier, Hendry, and Glades. The program has a management team that is comprised of the following positions: Vice President of Programs located in Tampa Florida; Statewide Director of CINS/FINS; Statewide Quality Assurance Director; Residential Services Manager; Non-residential Manager; a Licensed Clinical Social Worker (Counselor III); a Youth Care Supervisor (YCS III); and a Senior Administrative Assistant. The Statewide CINS/FINS Director supervises the program managers who are responsible for oversight of the CINS/FINS residential and non-residential programs as well as other programs operated by the provider in the Southwest Region. During the QI visit, the VPP indicated that the agency is currently undergoing changes due to growth of its programs. In particular, the Fiscal office has expanded as a result of the increased number of employees and addition of Early Start programs statewide. Sadly, two of its long time staff will be retiring at the end of the year: Tom Desio, Statewide Director of CINS/FINS, and David Yarborough, Vice President of Special Projects.

There are a couple of management changes as a result of new staff hired and/or staff promotion. The Residential Services Manager, Lori Iacobbo, was employed 1/21/14 to replace the former Residential Manager, Jeffrey Pyles. Two internal changes include the promotion of Lauren Swindle to Manager II position responsible for the Non-Residential program, and Tammy Noland's promotion as Youth Care Supervisor (YCSIII). At the time of the review, the program had six Youth Care temporary relief staff positions and two Counselor II positions vacant (one is a new position).

The program has an Annual Training Plan for each staff and orientation training is provided to all new hires. Employees receive ongoing training from local providers as well as the Florida Network. Each employee has a separate training file that contains a training plan and supporting documentation for training received. Annual training is tracked according to the employee's date of hire.

LSF Southwest maintains multiple interagency agreements with various community agencies that ensure a continuum of services for its youth and families. The program has an active outreach component with participation of all program staff who focus their outreach activities in designated high crime zip codes and low performing schools.

### 1.01 Background Screening

Satisfactory                       Limited                       Failed

#### Rating Narrative

LSF Southwest has a policy and procedures that address the screening of all Department employees, contracted providers, volunteers, and anyone who has direct and unsupervised access to youth. The agency's policy requires the screening to be conducted prior to hiring an employee or volunteer which is conducted using Live Scan. In addition to the DJJ Background Screening, the provider also conducts the following: a 3-year driver's record at hire with DMV; an annual valid driver's license check; annual local municipality and county background screenings; and a drug screening upon hire and randomly thereafter.

A total of twenty-six (26) background screening files for thirteen (13) new hire staff, seven (7) staff eligible for 5-year re-screenings, and six (6) volunteers/interns were reviewed. All thirteen (13) new hires were screened and had eligible screening results prior to their hire dates. Similarly, the seven (7) staff eligible for 5-year re-screenings were re-screened prior to their 5-year anniversary dates and the six (6) volunteers/interns were background screened with eligibility results prior to their start dates.

The provider submitted its Annual Affidavit of Compliance with Good Moral Character Standards on January 17, 2014 prior to the January 31<sup>st</sup> deadline.

### 1.02 Provision of an Abuse Free Environment

Satisfactory                       Limited                       Failed

#### Rating Narrative

The agency's Policy and Procedure, 1.02, addresses all of the requirements of the QI indicator. Staff is informed of the agency's Abuse Free policy during orientation via the Agency's Code of Conduct, the Agency's Policy and Procedures Manual, and Personnel Policies and Procedures. Staff acknowledges receipt of this information by signing an Acknowledgement Form which is maintained in their personnel file. New staff also signs an acknowledgement of receipt of the Abuse Reporting Requirement.

During the tour of the facility, the posting of the abuse hotline number was observed throughout the facility in the lobby, dorm hallways, bedrooms, and common areas. Rights and responsibilities are posted in the individual youth's bedrooms as well as throughout the facility. The

rights and responsibilities are also reviewed with youth during intake and signed copies are kept in the youth's case file. There wasn't any visible sign of graffiti observed during the tour of the shelter facility.

Youth are allowed to file grievances and are given access to forms and a depository box. There are two grievance boxes which are kept locked and are located in the dining room area and a hallway.

The Senior Administrative Assistant stated that there are no personnel actions implemented as a result of employee violation of policy. Three youth surveyed stated that they knew about the abuse hotline and two of three were aware of the location of the telephone number. Two of the three youth surveyed stated that they feel safe but only one of the three felt that the adults were respectful when talking with youth. The three staff surveyed said they have never witnessed another staff prohibit youth from calling the abuse hotline, neither have they observed staff using profanity, threat, intimidation, or humiliation when interacting with youth.

Six (6) grievances reviewed indicated complaint against staff regarding either physical and/or inappropriate verbal mistreatment. None of these serious allegations made demonstrated management's involvement in addressing the issues or resolving the grievances.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a written Policy, 1.03, and procedures for the notification of reportable incidents to the Department's Central Communication Center (CCC) within the two (2) hour timeframe. Incident Report training is included on the provider's training plan for new staff during program orientation. Additionally, there are protocols for communicating incidents to management on a daily basis as well as internal record keeping, monitoring, and tracking of incidents. The Incident Reporting Hotline numbers are posted throughout the facility in accessible areas of the facility.

The provider's procedures require staff responding to the incidents/accidents to immediately notify their direct supervisor and/or management during daytime hours or supervisor/designee during evening or weekend hours. Any unusual incident is documented on the Incident Reporting Form by the witnessing staff member. Upon notification, determination is made by management regarding how to proceed. Additionally, the QA Specialist keeps track of the number and severity of incidents and provides a monthly report. During the review period, ten (10) of the incidents reported to the Central Communications Center (CCC) were accepted. Of the ten incidents reported to CCC, four (4) were related to medication and/or medical incident, and one (1) each were due to: staff falsification of sight and sound information, abuse report, runaway, physical altercation, youth on youth sexual interaction, and program disruption.

All of the incidents were recorded on an Incident Report Form and included a summary of the incident and notification of appropriate authorities including the parent/guardian, and follow-up notes.

A review of three first year training files was conducted to determine receipt of Incident Reporting training during orientation. The training is listed on the training plan for the three new staff and was completed during orientation.

A review of the provider's documentation of the reported incidents was conducted along with a review of the provider's program logbook. Four of the ten incidents reported during the review period were not reported to CCC within the 2-hour timeframe required.

Staff is required to document the incident in the log book; however, only two (2) of the ten (10) CCC incidents reviewed were documented in the logbook and none of the ten (10) calls placed to CCC were recorded in the logbook.

Four (4) of the ten (10) incident reports did not include the times the calls were placed to CCC and/or times parties were notified. In addition, the reports do not include follow-up information or outcome of the incident and follow up with CCC. Also, the provider's form requires the reporter to include information on the date and time the reports were sent, person(s) to whom the reports are sent, and signature of person sending the report but all of the ten internal incident reports were missing this information.

A medication error reportable CCC incident occurred on 8/17/14 but was not called in to CCC. The Residential Manager was informed of the reportable nature of the incident during the review and the report was called in and accepted by CCC.

### 1.04 Training Requirements

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a comprehensive written policy and procedures to address staff training and has developed an annual Training Plan to ensure staff receives the necessary training to successfully complete job requirements. The agency provided a copy of their Annual Training Plan for the 2013-2014 Fiscal Year which included a monthly staff training schedule. The Training Plan for FY 2013-2014 was submitted to the Florida

#### Network.

The agency maintains an individual training file for each staff which includes supporting training documentation and attendance log. However, the training attendance log was not completed in 5 of the 6 files, and was missing for the current training year in one of the files.

A review of six training files for three first year and three in-service staff was conducted to assess compliance with the indicator. Orientation training was completed and documented in the three new staff files, with each completing 20 hours of on the job training. Behavior Management training is listed by the provider as a mandatory training for direct care staff and is completed during orientation of new staff.

None of the three new direct care staff had received Title IVE training and one did not have a copy of the CPR/First Aid certificate although it was documented as completed.

One of the three first year staff is not on target for completing the 80 hours of training required and had 33 of the 80 hours remaining with only one month left in the current training year.

A total of 3 in-service staff training files were reviewed. In general, staff is non-compliant in completing the 24 hours of training required annually. None of the 3 staff completed Fire Safety training in the most recently completed training year and one staff did not have a current CPR/First Aid Certification.

The training attendance log was not completed in 5 of the 6 files reviewed and was missing for the current training year in one of the files.

None of the three clinical staff training files reviewed showed completion of the Assessment of Suicide Risk training.

### 1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a written policy and procedures for analyzing and reporting data for case record reviews, incidents, accidents, grievances, customer satisfaction, outcome data, and monthly review of Netmis data reports. The agency's management team includes the Statewide CINS/FINS Director, QA Manager, Non-Residential and Residential Program Managers, Program Supervisors, and other key staff who are Chairs of the local CQI committees.

The agency's clinical staff conducts peer reviews of all active client files on a monthly basis. In addition, the Non-Residential Clinical manager conducts case supervision on a monthly basis with all non-residential Counselors and Case Managers and any issues identified from the peer reviews are addressed. File review findings are documented on the Non-Residential Peer Audit Review Checklist for each record reviewed.

Residential Case staffing is held weekly and include the Shelter Manager, Counselor, and Youth Care staff. The file review checklist is maintained in the youth's case file. The Residential and Non-Residential Manager prepare a Quarterly QIC Report which includes an analysis of incidents, accidents, and grievances. Reports for the first two quarters 2013 were reviewed. The reports include an analysis of incidents/accidents, grievances, and fire drills that occurred during the quarter, summary of case record reviews, reporting of performance measurements for the quarter, number and types of training provided to staff, and satisfaction surveys completed. In addition, the program's QA Specialist tracks and reports incidents/accidents, as well as trend data, on a monthly basis.

Consumer satisfaction data is included in the quarterly QIC Reports. Findings are regularly reviewed by management and communicated to staff and stakeholders. Strengths and weaknesses are identified, improvements are implemented or modified and staff are informed and involved throughout the process.

Monthly staff meetings are held for all program staff. During these meetings, all incident reports, grievances, and accidents are reviewed. Staff meeting agendas for the past six months were reviewed. The agenda always included an item for CQI to discuss incidents, accidents, grievances, follow ups, and satisfaction surveys. An agenda and sign-in sheets are available for each staff meeting.



## Standard 2: Intervention and Case Management

### Overview

#### Rating Narrative

Lutheran Services Southwest provides residential and non-residential services to youth ages 10 - 17. The Oasis Youth Shelter residential facility is located in Ft. Myers. The non-residential services provide services to four counties: Charlotte, Collier, Glades and Lee County. The Non-Residential program is under the direct supervision of a Program Manager who supervises the clinical team comprised of 7 Counselors (6 Counselor I and 1 Counselor II). The Non-Residential program is divided into two components, clinical and prevention/intervention. Referrals for services are received from parents, school, counselors, the court system, etc. Services provided include individual, family and group counseling along with case management services. Case management services include life skills, social skills and referrals for services upon the youth's return to the home. Youth also receive referrals for substance abuse and mental health services.

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

LSF SW coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. A case plan is created with the youth and family through recommendations through the case staffing committee. The case staffing committee may include representatives from the school district, DJJ or CINS/FINS provider, State Attorney's Office, Mental Health and Substance Abuse organizations, law enforcement, and DCF. Aftercare and discharge planning are also addressed prior to the youth's release. The Case Staffing Committee meets at a minimum six times monthly and can also recommend a CINS Petition be filed to court-order participation with treatment services.

### 2.01 Screening and Intake

Satisfactory

Limited

Failed

#### Rating Narrative

A written Policy and Procedure is in place in regards to centralized screening and intake. The Policy and Procedure address policy, procedure and practice. Intake services are available twenty-four hours a day, seven days a week. A NetMis screening form is completed on all youth for eligibility purposes. Six of seven files had the eligibility screening completed within the seven day period, while one file was originally referred eight months prior and no re-screen was completed on the youth.

During the intake process for residential youth a handbook is provided to the youth and family which indicates general service options such as individual, family and group counseling. However, no specific service options are provided to the family. All three files met the requirement. For non-residential services all three files were provided the service options.

Information regarding possible actions occurring through involvement with CINS/FINS services was provided to all three non-residential client files reviewed. This was documented through the use of a specific form. However, the same document was not used in the residential setting and there was no documentation that indicated that possible actions were reviewed in the files of the three residential youth whose files were reviewed.

The residential files indicate the core services such as individual, family and group counseling in the handbook, but do not go into the types of services that the youth will be receiving until after the Needs Assessment and Case Plan is completed. Youth and families may be unaware of additional services the youth may receive in the residential setting.

The program provides non-residential youth information on possible actions occurring through involvement with CINS/FINS services, but no information is given to residential youth on this topic.

### 2.02 Psychosocial Assessment

Satisfactory

Limited

Failed

#### Rating Narrative

A written Policy and Procedure is in place in regards to the Needs Assessment. The Policy and Procedure address the requirements of the indicator.

A total of six files comprised of three Residential and three Non-residential case files were reviewed. All three residential files reviewed contained Needs Assessments that were completed within 72 hours of admission. The Needs Assessments for the three non-residential youth were completed by staff on the date of intake for the client.

All six files reviewed had Needs Assessments completed by a Bachelor's or Master's Level staff and were reviewed by a supervisor with signatures.

All three non-residential files reviewed indicated that there was an elevated risk of suicide based upon collateral information received, but not specifically due to answers provided on the CINS/FINS Intake Assessment suicide risk screening. In all three files the youth were referred to outside agencies for an Assessment of Suicide Risk (ASR). However, a copy of the actual (ASR) was not located in the file. Documentation that staff followed up with the referrals were documented.

In all three non-residential files reviewed there was confusion on suicide risk screenings. In each case the youth did not answer 'yes' to suicide risk screening questions, but staff received collateral information which caused them to make a referral for an Assessment of Suicide Risk. A suggestion would be to make sure that documentation clearly defines why a youth is being referred for a screening and that staff are clear on the difference between a suicide screening and suicide risk assessment. Specific answers on a screening will mandate an assessment being completed.

### 2.03 Case/Service Plan

Satisfactory

Limited

Failed

#### Rating Narrative

A written Policy and Procedure is in place in regards to the Case/Service Plans. The Policy and Procedure address all the requirements of the indicator.

A total of six files comprised of three Residential and three Non-residential case files were reviewed. All six files were developed within the seven day timeframe. All six files were individualized and prioritized based upon the needs and goals identified during the assessment. All six case plans addressed the following:

- Service type, frequency, and location
- person responsible
- target dates for completion
- signatures of youth, counselor and supervisor
- date the plan was initiated

Two of the three residential files reviewed had Case Service Plans where there was no parent signature. One of the six indicated that "the parent concurred," with the plan. Another did not have a parent signature at all. In one of the three non-residential files, revisions were due but not completed. In addition, the revision of the plan was completed outside the 30 day window in one of the non-residential files.

### 2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

#### Rating Narrative

A written Policy and Procedure is in place for Case Management and Service Delivery. The Policy and Procedure addresses all the requirements of the indicator.

A total of six files comprised of three Residential and three Non-residential case files were reviewed. In all six cases reviewed there was a case manager/counselor assigned to the youth. In each case, referrals were made for the appropriate services and documentation was provided to substantiate additional referrals for services and completion of follow ups. The completion and follow up for services was evident throughout the documentation both on the service plan as well as in the notes. Contact with the youth and families was well documented. There were no out of home placements necessary in the files reviewed as well as no referrals to the case staffing committee. In cases where youth and families were having issues there was documentation of assistance and follow up by the case manager/counselor.

### 2.05 Counseling Services

Satisfactory

Limited

Failed

### Rating Narrative

A written Policy and Procedure is in place for counseling services. The Policy and Procedure addresses all the requirements of the indicator.

A total of six files comprised of three Residential and three Non-residential case files were reviewed. In all six cases reviewed the youth and/or family were receiving the appropriate counseling based on the case/service plan.

For the three residential files reviewed, one of the three was receiving individual and family counseling. In one case there was contact with the parent but no family sessions were documented. In another the youth just began services within the last two weeks.

The program does provide group counseling 5 days per week. A schedule for the groups being provided is posted in the Shelter. In all six files the youth's presenting problems are addressed in the needs assessment and case/service plan. In three of the six files reviewed counseling was addressed during the case service plan reviews. In two of the six the youth had not been in service long enough for a review and in another the supervisor had the case in question on her caseload, but no supervisory review was completed by another management team person. The case notes for the individual and family counseling were excellent. The notes clearly defined the type of counseling as well as progress and follow up.

## 2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

### Rating Narrative

There is written Policy and Procedure of the Adjudication/Petition Process. The Policy and Procedure addresses the requirement of the indicator.

There is an established case staffing committee that consists of representatives from school district, CINS/FINS provider, mental health partners, substance abuse partners, law enforcement and DCF. Not all representatives attend all meetings, but there is documentation that representatives from those types of agencies attended the meetings at least once in the three cases reviewed.

In all three cases reviewed, the youth was referred to the committee (TURN Committee) by a counselor. Notification to the committee is sent via e-mail about placing a youth on the list. In two of the three files there was a letter sent to the parent, more than 5 working days prior to the staffing, informing them of the case staffing committee date. A new or revised plan of service was not completed in two of the three files reviewed. There was documentation that the parent and/or youth were at the staffing and were aware of the recommendations as they signed off on the review sheet, but no new plans were created on the two files where the youth was already receiving services. None of the three files required circuit court or judicial intervention.

In two of the three cases reviewed there was no revised plan for services for a youth already in services after the case staffing committee recommendations. In one of the three cases the youth and parent were at the case staffing and were aware of the recommendations, but the plan was not revised. In the other case the youth did not show for the case staffing, but the parent did appear and was aware of the recommendations. The youth was placed in the Shelter shortly after the committee review.

## 2.07 Youth Records

Satisfactory

Limited

Failed

### Rating Narrative

There is a written Policy and Procedure for Youth Records. The Policy and Procedure addresses the requirement of the indicator.

A total of six files comprised of three Residential and three Non-residential case files were reviewed. Each youth's record contains the pertinent information in the case. All records were marked confidential and kept in a secure cabinet behind a locked door. All files were neat and orderly. Sections in each file were separated by divider sheets which indicated paperwork in each section as well as by tabs. The files were consistently organized and maintained in a professional manner.

## Standard 3: Shelter Care

### Overview

#### Rating Narrative

The Oasis Youth Shelter is licensed by the Department of Children and Families (DCF) as a twenty-two bed Child Caring Agency through January 31, 2015. The facility is also licensed to provide children's substance abuse services for Prevention Level 1 and Outpatient Treatment through June 6, 2015.

The shelter provides short-term respite residential services to youth ages 10-17 in the Department of Juvenile Justice (DJJ) CINS/FINS program as well as for youth from the Department of Children and Families DCF. The CINS/FINS youth typically do not currently have any open cases of delinquency or dependency. With the exception of court ordered CINS youth, the services are voluntary in nature and no fees are charged to the clients, parents or guardians. This shelter is designated by the Florida Network to provide staff secure services and Domestic Violence (DV) respite. There were no Staff Secure youth in the shelter during this review; however, there were two active DV youth in shelter.

The shelter program management team is comprised of a Residential Services Manager and a Youth Care Supervisor (YCSIII). Each shift also has a YCSII who is the designated team leader. An organization chart dated 8/21/14 shows a total of twenty-five (25) Youth Care positions in the shelter program, six of which were vacant during the review. The six vacant positions were for Temporary Relief YCS. There are also three residential counseling positions, one of which is occupied by the Licensed Clinical Social Worker (LCSW) and a Substance Abuse Counselor I. Clinical services are supervised by the LCSW Counselor. Services provided include individual, group and/or family counseling, and any other applicable intervention required.

### 3.01 Shelter Environment

Satisfactory

Limited

Failed

#### Rating Narrative

There is a written policy and practice in place to ensure a safe environment for both the clients and staff.

During the visit, the Residential Program Manager gave the Reviewers a tour of the facility. This Reviewer observed the following items during and after the tour:

- There are 16 functioning cameras in place throughout the program and a monitor that the staff can observe from inside the office. It stores up to 30 days of recordings.
- There were no sightings of infestation or graffiti. Staff checks the walls, doors and windows for graffiti during their inspections. The entire building was recently tented for bed bugs due to an infestation. New metal bunk beds were purchased due to the bugs residing in the wood frames of the old beds.
- The client rooms were clearly numbered and each youth had an assigned bed. Youth were allowed to decorate their room area. The walls of the bedrooms had painted murals that created a home like atmosphere.
- Daily schedules were posted throughout the shelter, that includes physical activity, home work, reading and faith based opportunities. The back yard had a large space for basketball.
- The grounds were well maintained and there was visibly new mulch and plants. The garden vegetable area once maintained by volunteers and youth had become in disrepair.
- One 15 passenger van was inspected. This van was brand new. The doors were locked and the van contained a fire extinguisher, first aid kit, flashlight; the seat belt cutter and glass breaker was a Swiss Tech tool that was on the key chain.
- The program had (1) washer and (1) dryer that were in working order.
- The chemicals were locked in the chemical closet and MSDS sheets are maintained with daily chemical counts.
- All required inspections, which included Fire Safety, Health and DCF Licensure, were up to date. The health inspection had a violation of bare wood around pass through kitchen window. The fire report had (3) violations that are to be corrected by 9/22/2014: mag light not working/fire horn strobe blocked, emergency light in girl's bathroom needs repair and door holders on doors, remove door stops.
- Other shelter observations included that the youth have a spot to place valuables or personal items in a locked place.
- The grievance box was observed down the girl's hallway.
- Three first aid kits were observed and were fully stocked.
- The shelter had a knife for life and the wire cutters were locked with the sharps.
- Zee Medical Supplies Company maintains the first aid kits and handles the biomedical waste. There is a container for sharps, but not for larger soiled items.
- Two successful mock emergency drills were completed for the last two quarters.
- Other inspections that were up to date included: kitchen exhaust system, fire extinguishers and fire suppression system.
- In the girl's bedroom #3 there was one light out and in the boy's bedroom #2 there were lights out.
- In the girl's bathroom the vent was rusty. No non-slip mats were found in shower areas.
- Bathroom stalls had a curtain rod with shower curtains for privacy. Staff indicated that the stall unit has to be completely replaced which

is too costly at the moment. Therefore, only one youth at a time is allowed to use the toilets to safeguard privacy.

- In the backyard a 4" by 4" metal pole stood about waist high and had sharp edges on it. This pole has to be removed as it is a safety hazard. It sits just west of the concrete deck just outside of the back door.

### 3.02 Program Orientation

Satisfactory

Limited

Failed

#### Rating Narrative

The shelter has a written policy and practice in place that allows the youth to have a positive orientation process. The policy and procedures address all the requirements of the indicator.

Three (3) residential case files were reviewed and all three contained the required orientation documentation. In all 3 files the youth and parent signed that they received the Youth Orientation handbook. The orientation check list was initialed by each youth. There is a private office to conduct intakes and at this time the intake staff reviews the program rules and expectations and the behavior management system with the youth and parent/guardian. If present each youth and parent are provided with the orientation handbook which includes: description and map of program, list of current program staff, program rules, grievance procedures, disaster plan, and client rights and responsibilities.

A total of 24 grievances for the review period were reviewed. Thirteen (13) of the grievance forms reviewed did not have staff signature or date, 16 of the 24 grievances did not indicate that a solution was acceptable or not, and 9 out of the 24 grievances, the youth did not sign. Some of the grievances involved complaints against staff that were unresolved according to the grievance forms section of solution acceptable or not. Examples of complaints against staff include the following dates: 6/21/14, 6/22/14 (2), 8/12/14, 8/29/14, and 8/31/14.

### 3.03 Youth Room Assignment

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a written policy and practice in place to assign each youth to an appropriate room. The process includes an initial classification that includes: age, gender, youth's history, status, exposure to trauma, history of violence, disabilities, physical strength, gang affiliation suicide risk, sexually aggressive and gender identification.

Three (3) files were reviewed and all 3 files contained documentation to properly place youth in an assigned room. If a youth is placed on sight and sound they will sleep on the sofa in the day room where a staff member is always located. There was one youth on sight and sound and staff was observed on camera with the youth and a record of documented checks was in the youth file.

Room checks were observed on camera showing staff conducting them and a record of room checks was in the youths file.

There is an alert system in place to notify staff of any special needs. The alert board is clearly labeled with alert issues and color-coded dots.

During the room assignment the youth and staff member complete the client room checklist for any graffiti, broken or damaged items etc. The youth takes responsibility for any damage created while they are at the shelter.

### 3.04 Log Books

Satisfactory

Limited

Failed

#### Rating Narrative

There is a written policy and practice in place for the log book. The log book dated 7/31/2014 from 4:55 pm was reviewed. Entries include date, time, person(s) involved, brief statement providing information, and a signature of the person recording the entry. Important information is highlighted through the log book.

Six (6) recording errors, noted in the first 50 pages, did not have a single line struck through them and were missing initials or date.

Staff coming onto shift are not consistently signing in or documenting that they were reviewing the log book for the previous two shifts.

The provider's policy states that Incident Reports will be documented in the log book; however, a review of the log book showed that incidents were not being recorded consistently in the log book. Five of nine incidents reviewed were not documented at all in the log book. Four of the incidents were documented but the CCC calls were not noted. In addition, three incidents from August 17, 27th and 29th were reviewed and none of the CCC calls were noted in the log book.

Rating Narrative

The provider has a policy and procedure in place for the behavior management system.

The system is designed for not only compliance to the rules, but to change the behavior of the youth and increase accountability. Consequences are built into the program for violation of the rules that are logically and consistently applied. The program uses a variety of rewards and incentives to encourage participation and completion of the program. There is a protocol for providing feedback.

The system is designed to: maintain order and security; promote safety, respect, fairness and protection of rights; provide constructive discipline with positive and negative consequences to encourage the youth to meet behavioral expectations; provide opportunities for positive reinforcement and recognition, peaceful resolution; and minimize the separation of youth from the general public.

There are three levels within this system and they are: Ownership, Citizenship and Leadership.

All youth begin on the Citizenship level and expectations are to follow shelter rules with minimal behavioral issues.

The goal would be to reach the Leadership level to achieve the highest expectations and most rewards. Youth not following the 7 graded areas or committing a serious offense within the program may be lowered to Ownership level with reduced privileges.

The 7 key areas include: morning wake up and hygiene, school attendance and participation, dinner chores, group counseling attendance and participation, and an overall emphasis on respect and safety.

Behavioral interventions use the least amount of force necessary. Counseling, verbal interventions and de-escalation techniques are used prior to physical intervention. Only staff discipline youth, no group discipline is permitted, no room restrictions are used and discipline measures do not deny basic rights.

The program has a variety of rewards that include: Pax rewards box, prize cabinet, paid outings for earning all points for the week, daily free outings, and ability to call up to 2 friends on their approved list.

Three of three staff training files shows that staff was trained in the behavior management system.

### 3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The provider has a policy and procedure in place to ensure that adequate staffing is provided for the safety and security of the youth. The policy and procedures address all the requirements of the indicator.

Staff schedules for the past 6 months were reviewed and staff to youth ratios is being met for the 1:6 ratio requirement during waking hours as well as 1 staff to 12 youth during sleeping hours.

Staff schedules are posted in the intake office. Hold overs are in place if another staff member is running late.

Staff completes room checks every 15 minutes and documentation of the checks is maintained in the log book. Staff was observed on camera conducting room checks and a written record of corresponding room checks was in the youth's file.

Both female and male youth are represented on all shifts by a staff with the same gender except on the Friday and Saturday overnight, 11-7 shift, for the past 15 weeks. There has been only female staff on 12 of the last 15 weeks on the Friday and Saturday overnight shifts.

### 3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

There is a current policy and procedure in place to ensure proper protocols are in place to provide services for youth meeting Staff Secure or Domestic Violence criteria.

During the visit, there was no staff secure youth in the shelter and per the Residential Manager, no staff secure youth had been admitted since

the last onsite QI visit.

Two (2) files were reviewed for Domestic Violence (DV) youth that were active in the shelter during the review. These 2 youth were referred from the local JAC Center. Their stay has not exceeded 14 days and the case plan goals in the clinical notes, assessment, and treatment plan reflect goals that are focused on aggression management. All other services provided to the general CINS/FINS program population are made available to these youth.

There were no probation respite youth in shelter during the review.

## Standard 4: Mental Health/Health Services

### Overview

#### Rating Narrative

LSF SW has specific procedures related to the admission, interviewing, and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. Upon admission, program staff will interview youth. An initial assessment occurs to determine the most appropriate room assignment given the youth's needs and issues, the current population at the facility, physical space available and staff's assessment of the youth's ability to function effectively within program rules and expectations. Staff conducting the initial interview and assessment considers the youth's physical characteristics, maturity level, history including gang or criminal involvement, potential for aggression, and apparent emotional or mental health issues. Based on this information, the youth is assigned a room which can change after further assessment. Room assignment is documented on the CINS/FINS Intake Assessment page 2.

Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The Residential Manager and/or Youth Care Supervisor is notified immediately if risks and/alerts are present; recommendations regarding placement and supervision are provided to the direct care staff. This information is documented in the daily log, on the alert board, shift exchange forms, and in the youth files using a color coding system.

Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission. Medications are stored in a locked cabinet, and topical and/or injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication ensures that an approved staff is scheduled on each shift. Medication records are maintained for each youth and stored in a Medication Distribution Log binder.

### 4.01 Healthcare Admission Screening

Satisfactory
  Limited
  Failed

#### Rating Narrative

The program has written policy and procedures to ensure medical care for youth admitted to the program. Staff also receives training on the intake and admission process. There is a list of staff who are approved to administer medication that is posted in the medical room.

Practice was exhibited in the four (4) files reviewed. Of the four files reviewed, all the files document that the program performs preliminary physical health screening for each youth at the time of admission to the shelter.

Of the four cases reviewed for indicator 4.01, one youth who had allergies was documented on the CINS/FINS Intake form but that information was not checked off, documented, or indicated on the Shelter Screening Form.

Medical care for youth admitted with chronic medical conditions is provided through referrals to community agencies for treatment. The Agency's policy and procedure includes the process for referring youth for medical care and for chronic medical conditions.

### 4.02 Suicide Prevention

Satisfactory
  Limited
  Failed

#### Rating Narrative

The provider has a policy and comprehensive procedures in place that address this specific indicator. The procedures are clearly stated and provide a protocol for identifying and providing the needed services for those identified with suicidal ideation during the intake process. The procedures include placing the youth on sight and sound until an Assessment of Suicide Risk is completed by a Masters Level Counselor under the supervision of a Licensed Mental Health professional. The procedures also refer to observation by staff of behavior which may be concerning regarding the youth's mental status and placing them on sight and sound for further evaluation.

All four cases reviewed had a Suicide Risk Screening done at intake. These were all signed off by a supervisor; however, apart from one case, Suicide Risk Screenings were not specifically documented in the intake progress notes as being completed, per the indicator, though that was inferred in the content of other written documentation that was made at the time. Three of the four youths were placed on sight and sound supervision; however, in one case, the youth was placed on sight and sound but there is no documentation or Suicide Risk Assessment on file to support this decision. In addition, the sight and sound logs for one of the youth was found in another client's case file and the former youth's progress notes did not make mention of this client being on sight and sound. The agency uses a combined filing system for keeping sight and sound logs. These records are then transferred to individual files once they are completed and typically within 24 hours.



In all three cases where sight and sound was implemented, the supervision level was not changed until the licensed Manager completed a further assessment. The follow up screening assessment for one youth was very well documented on the appropriate form and signed off by a LMHC. The agency's Residential Shelter Manager is currently a LMHC and signs off on the required Suicide Risk Assessments and other relevant documentations. Her current license was reviewed and noted.

#### 4.03 Medications

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has policy and procedures in place to address the requirements of the indicator.

All medication is stored in a separate, secure area behind a locked door inside the Intake Office. Only staff has access to this room. Inside the medication room, the storage of prescribed and over-the-counter medications is kept separate. Similarly, there is separation of injectable and topical medications as well as refrigerated ones when used. All medications are kept in a locked cabinet and individually stored in unlocked plastic boxes for each client.

Agency controlled and narcotics medication needs to be stored behind two locks (the door to the office is not counted). The agency addressed and corrected this issue during the review by providing a locked and appropriately labeled secure box while reviewers were still on site.

There is an updated list of staff available who are authorized to distribute medication to youth. The list was checked against several training files and training facilitated by DJJ Nurse Gurk in June 2014.

Controlled medication is counted perpetually with running balances. Shift-to-shift inventory counts are conducted and are documented. Similarly, over-the-counter medication is inventoried weekly and perpetual balances are maintained on a daily basis.

Client case files have a separate medical section that includes medication information but very little or no documents were present in the files reviewed, even if the youth is on medication. Instead, medication records log is combined for all youth in a Medical Distribution Log (MDL) binder.

Three of the four youth whose cases were reviewed were on medication. There is inconsistency in the documentation that is maintained in the medication section of each youth's file. One youth has a consent form and copy of Medicaid card; another youth has medical card only; a third youth has a copy of medical card and consent form; and the fourth youth has no documentation.

Further observation of the MDL binder found more medical and medication information included. There were individual MDL sheets for each youth but one had no client name and signature on the face sheet. There were no side effects information for the same youth and allergy information was missing on several MDL sheets for two youth; these were corrected by staff immediately.

#### 4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

##### Rating Narrative

Agency has a written policy and procedure to address Medical, Mental Health Alert, Emergency Mental Health and Substance Abuse Services that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, food and medication contraindication, and other pertinent treatment information is effectively communicated to all staff through the alert system. There is a nutritional alert board located in the kitchen.

One of four case files reviewed showed that one youth had a nutritional alert but that was not on the board. On closer review, there was no documentation from initial screening that the youth had any allergies.

The alert system is a color coded system that is communicated to staff through the program logbook, the alert board located in the medical room (staff this this each shift to show that that they have reviewed the alerts once they come on shift), and documented in Alert Binder kept the Intake office, and in the youth's individual case file.

The Client Alert System identifies as follows: Red=Medication; Blue=Medical Green= Substance Abuse; Yellow= Elevated Supervision; Black= Mental Health; Dark Green=Physically Aggressive; Pink=Chronic Runaway; Orange=Allergies, Light Blue=Sight and Sound. One staff was interviewed and adequately explained the process consistent with agency policy and procedures.

#### 4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has policy and procedures to address Episodic/Emergency Care that includes a very extensive first aid procedures and specific medical related guidelines. The agency's written procedures address the provision of Alert System Protections Log which upon interviewing staff, that log is not used or in place. Parental notification forms are part of the intake process and were on files, in that section. Verification of receipt of medical clearance, discharge instructions and follow-up care is to be received upon youth return to shelter and is placed with the incident report, then disseminated to the client's file. There was evidence of this received for three cases that were reviewed for incident occurring on 09/01/2014.

The written policy and procedure require that mock emergency drills are conducted a least quarterly and the agency documented that the required emergency drills were conducted for the last two quarters ending in April 2014 and August 2014.

Knife-for-Life and wire cutters are located in various places: Shelter Manager Office, Medical room and one that should be located in another office location was missing. The two vans assigned to the facility had knife for life on the key chain and First Aid kits. First Aid Kits are also seen and accounted for in the building day room, counselor's office and medical room. Inventory are completed and updated by a third party company, these were available and updated, as checked weekly. Staff is trained in CPR and First Aid and basic emergency medical procedures.

The agency recently developed a Daily Log for occurring Episodic/Emergency medical situations that document the client's medical concern, transportation use, parental contact and documentation of medical clearance given. The Episodic Log book was reviewed and noted to have begun on September 1st 2014. There is no previous record of the practice prior to that date.