



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

Review of LSF SE- Lippman

on 01/11/2018

## 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 3: Shelter Care

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

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

### Standard 2: Intervention and Case Management

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

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

### Standard 4: Mental Health/Health Services

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

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

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

## Rating Definitions

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

Satisfactory Compliance	Non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.
Not Applicable	Does not apply.

## Review Team

### Members

**Marcia Tavares, Lead Reviewer and Consultant, Forefront LLC.**

**John Robertson, Program Services Director, Florida Network of Youth and Family Services**

**Abraham Greene, Case Manager, Urban League of Palm Beach County**

**Lashonda Chavis, Director of Admissions, Miami Bridge Youth and Family Services**

**Mercedes Williams, Residential Counselor, Florida Keys Children's Shelter**

### Persons Interviewed

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Chief Executive Officer        | <input checked="" type="checkbox"/> Executive Director     | <input type="checkbox"/> Chief Operating Officer            |
| <input type="checkbox"/> Chief Financial Officer        | <input checked="" type="checkbox"/> Program Director       | <input checked="" type="checkbox"/> Program Manager         |
| <input checked="" type="checkbox"/> Program Coordinator | <input checked="" type="checkbox"/> Direct- Care Full time | <input checked="" type="checkbox"/> Direct-Care Part Time   |
| <input type="checkbox"/> Direct-Care On- Call           | <input type="checkbox"/> Volunteer                         | <input type="checkbox"/> Intern                             |
| <input checked="" type="checkbox"/> Clinical Director   | <input checked="" type="checkbox"/> Counselor Licensed     | <input checked="" type="checkbox"/> Counselor Non- Licensed |
| <input checked="" type="checkbox"/> Case Manager        | <input type="checkbox"/> Advocate                          | <input checked="" type="checkbox"/> Human Resources         |
| <input checked="" type="checkbox"/> Nurse               |  |   |
| 2 Case Managers   | 11 Maintenance Personnel                                   | 2 Clinical Staff  |
| 2 Program Supervisors                                   | 1 Food Service Personnel                                   | 02 Other  |
| 1 Health Care Staff                                     |  |   |

### Documents Reviewed

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Accreditation Reports                        | <input 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 checked="" type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports                       | <input checked="" type="checkbox"/> Key Control Log                  | <input checked="" type="checkbox"/> Youth Handbook  |
| <input checked="" type="checkbox"/> Logbooks                          | <input checked="" type="checkbox"/> Fire Drill Log                   | 4 # Health Records                                  |
| <input type="checkbox"/> Continuity of Operation Plan                 | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 4 # MH/SA Records                                   |
| <input type="checkbox"/> Contract Monitoring Reports                  | <input checked="" type="checkbox"/> Table of Organization            | 16 # Personnel Records                              |
| <input type="checkbox"/> Contract Scope of Services                   | <input checked="" type="checkbox"/> Precautionary Observation Logs   | 7 # Training Records                                |
| <input checked="" type="checkbox"/> Egress Plans                      | <input checked="" type="checkbox"/> Program Schedules                | 2 # Youth Records (Closed)                          |
| <input checked="" type="checkbox"/> Fire Inspection Report            | <input checked="" type="checkbox"/> Telephone Logs                   | 6 # Youth Records (Open)                            |
| <input type="checkbox"/> Exposure Control Plan                        | <input type="checkbox"/> Supplemental Contracts                      | 0 # Other   |

### Surveys

3 Youth                      3 Direct Care Staff

### Observations During Review

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

### Comments

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

Rating Narrative

## Strengths and Innovative Approaches

### Rating Narrative

Lutheran Services Florida (LSF) is a statewide, non-profit, human services agency with its headquarters located in Tampa, Florida. The agency's mission is to bring healing, help, and hope to all people in need regardless of religious affiliation, age or national origin. Since its establishment in 1982, LSF has helped nearly over 900,000 children and families. The agency has more than 60 programs located throughout Florida and provides a variety of services including: Child Care Food Program, Head Start and Early Head Start, Foster Care and Adoptions Case Management, Youth Shelters and Family Crisis Counseling Programs, Guardianship Program, Housing, Employment, Refugee and Immigration Programs, Ryan White AIDS Program, and Disaster Response Programs for victims of tornadoes, hurricanes, floods and other natural disasters. ? Lutheran Services Florida Inc. was accredited by the Council on Accreditation (COA) in 2005 and was recently re-accredited for the next 4 years by COA.

Lutheran Services Florida Southeast (LSF SE) is a Children In Need of Services/Families In Need of Services (CINS/FINS) program that provides residential and non-residential services to youth in Broward County. The program operates the Lippman Youth Shelter, located in the City of Oakland Park, Florida. The shelter provides twenty-four hours, seven days per week, crisis emergency services for youth under 18 years of age that do not have any current open cases of delinquency or dependency in Broward County. The Administrative Office and the Non-Residential Program, also known as Broward Family Center, is located on the second floor of the Lakes Medical Center Building at 4185 North State Road 7 in Lauderdale Lakes.

The southeast region is under the leadership of Gregg Miller, Program Director. LSF Broward is a current member of the National Safe Place Program, a network of voluntary community sites where youth in need of help can go for safe refuge. As a result of partnering with Safe Place, the program maintains over 100 Safe Place Sites in Broward County. LSF Southeast has developed and maintained several interagency agreements and Memorandums of Agreement (MOUs) with over thirty agencies that ensure a continuum of services for the youth and families, including schools, mental health, and substance abuse providers. The program has designated staff to conduct outreach. Outreach activities focus on designated high crime zip codes as well as low performing schools.

In addition to the CINS/FINS program, LSF Broward also serves the transitional age-group of at risk youth ages 17-21 years who are transitioning into adulthood. Through its partnership with Broward County "Second Chance" Program, LSF Broward is now also able to provide case management services to this population. The Second Chance program provides housing-focused case management and one year of housing and utility subsidy for these older youth, enabling them to learn how to budget, to save money, to locate and utilize community resources, and to put into practice the real-world life skills they are learning.

Since the last review, LSF has had some changes in personnel. The former Clinical Director resigned and the position was filled in-house by the Counselor III from the Lippman Shelter. In addition, the Youth Care Supervisor's position was vacated by a terminated staff and a former YCS II was promoted to the supervisory position.

Lippman Youth Shelter was once again awarded the Health and Human Services Basic Center grant in 2017.

The Residential Program Manager has implemented some new educational and career development activities for youth. With the support of the community, Lippman will mentor teens about the importance of professionalism and building self-confidence for a successful interview. The Interview 4 Success Program is held monthly where youth are required to dress in business attire and are instructed on professionalism and interviewing skills. Another new activity launched by the program is the Master Chef Cook Off. The Cook Off utilizes volunteers from the community who teach youth how to cook different recipes. Youth are grouped to compete in a cook off and winners are selected and awarded. On the last Friday each month, staff engage in fun recreational activities and compete against the youth in Staff vs Youth games.

## Standard 1: Management Accountability

### Overview

#### Narrative

LSF Southeast operates both the Lippman Youth Shelter (residential) and Broward Family Center (non-residential) CINS/FINS Program in Broward County. The CINS/FINS program has a management team that is comprised of an Executive Program Director; a Shelter Services Manager; a Licensed Clinical Supervisor (Counselor III); and a Senior Administrative Assistant. At the time of the review, the program had three vacant positions for one Counselor, one fulltime Youth Care staff (YCS), and one part time YCS.

The Program Director oversees the general operations of LSF Southeast programs. The shelter program staff structure includes: a Residential Program Manager, two Master's level Counselors, a Youth Care Supervisor (YCS III), one YCS II, 9 fulltime YCS I, and five temporary YCS I. In addition to the Clinical Supervisor, the non-residential component has five Counselor positions (4 FT and 1 Temp) and a Lead Program Assistant.

The program has an Annual Training Plan for FY 2017-2018. Each year the plan is reviewed, revised, and approved. The plan includes mandatory training for all staff including orientation training for new hires and an in-service component. Employees receive ongoing training from Skill Pro, local providers, and 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 Broward maintains several interagency agreements with over thirty agencies that ensure a continuum of services for the youth and families. The program also has an Outreach Targeting Plan and a strong outreach component with participation of all program staff and emphasis on the designated high crime zip coded areas as well as low performing schools.

The Department of Children and Families has licensed Lippman Youth Shelter as a Child Caring Agency, with the current license in effect until June 27, 2018.

### 1.01 Background Screening

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a Policy and Procedures, 1.01 "Background Screening of Employees and Volunteer," that was last revised and approved on 10/27/17. The policy and procedures comply with the requirements for background screening of all Department of Juvenile Justice employees, contracted providers, and volunteers as well as anyone else with direct and unsupervised access to youth.

DJJ background screenings are required to be conducted prior to the hiring of employees or volunteers.

The agency's Senior Administrative Assistant will check the Care Provider Background Screening Clearinghouse to see if the applicant has a current background screening on file. If the prospective employee's record is not found, the agency will proceed with the submission of a Live Scan. Prospective employees and volunteers are required to complete the appropriate forms required for fingerprinting. Upon receipt of an eligible screening result, the agency will formally make an offer of employment. In addition to the DJJ Background Screening, the provider also conducts driver's license screening for new hires, quarterly driver's license screening for existing staff, annual local municipality and county screenings, and a drug screening upon hire and randomly thereafter. Employees and volunteers are re-screened every 5 years of employment. The agency updates the Affidavit of Compliance with Good Moral Character Standards annually and submits the Affidavit with corresponding attachments to DJJ by January 31st.

A total of ten (10) background screening files were reviewed for eight (8) new hires, two (2) interns, and six (6) volunteers. None of the provider's staff were eligible for a five-year re-screening as of the most recent QI review conducted on November 30, 2016. All eight (8) new hires were screened and received an eligible

screening result prior to their hire dates. Similarly, the two (2) interns and six (6) volunteers utilized by the provider during the review period were background screened and eligible screening results were obtained prior to their volunteer start dates.

Proof of the faxed submission of the Annual Affidavit of Compliance with Good Moral Character Standards was provided along with evidence showing it was sent to DJJ on January 17, 2016 prior to the January 31st deadline.

No exceptions were noted to this indicator as of the time of the QI Visit.

#### 1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

##### Rating Narrative

The program has a policy for 1.02 "Provision of an Abuse Free Environment" which was updated last on October 27, 2017.

The program has procedures for: 1) ensuring a code of conduct that prohibits physical abuse, profanity, threats or intimidation, and are not neglected of basic needs; 2) mandating the reporting of all allegations of abuse to the abuse hotline; 3) a process for filing of grievances; and 4) requiring management to take immediate actions to address incidents of physical and/or psychological abuse or staff's failure to adhere to the agency's behavioral policy.

The agency's code of conduct is provided to all new staff members upon hire during their new employee orientation. This information is contained in their agency's Personnel Policies and Procedures manual, and acknowledgement of their receipt of this information is signed by employee and kept in their personnel file. The program clearly communicates staff's responsibilities and agency protocol for reporting of suspected child abuse. Staff also receives training about how to handle these cases; they are to immediately report all allegations of child abuse or suspected child abuse to the Abuse hotline. Furthermore, all reports are to be documented in youth's file and a copy of the faxed report is to be placed in a binder.

Upon entry into the program, youths are informed of their rights and responsibilities, the agency's grievance process, and how to place grievance forms in the "grievance box" which is located in an accessible location in the facility.

The program has the Florida Abuse Hotline number posted throughout the facility. Florida Abuse hotline postings can be found in the hallway to common area in all youth bedrooms and in the therapy room. Agency is following its stated policy of keeping a log for recording of child abuse hotline calls in logs and documented in client case files. Reports are being made within 2 hours of knowledge of incident, or may result in disciplinary actions against staff. Documentation of communications between employees and youth reporting abuse is properly being noted in program log and client file. Staff adheres to a Code of Conduct that requires staff to report any issues of abuse. The agency's policy on child abuse reporting is in compliance with Florida Network and DCF's policy.

A total of 20 cases reviewed were called into the hotline during the review period. DCF accepted 18 out the 20 cases called in. Reviewer found that the Abuse Report Log contained a roster of calls and a separate section with additional detailed information about each of the report.

A total of 7 grievance forms were reviewed for period between July 2017 and December 2017. These grievances reported by youth ranged from issues such as poor food quality to staff member interaction issues. The manager was able to address these issues within 24 to 72 hours and provide resolutions which were accepted by youth within 72 hours of receiving the form.

Within the last year agency has not had to take any action regarding physical and/or psychological abuse, verbal intimidation, use of profanity, and/or use of force.

Three staff members and three youth were surveyed. One of the three staff surveyed indicated that working

conditions at the shelter was poor, one indicated good, and one stated very good. All three staff confirmed being trained in child abuse reporting; all three have made calls to the Florida abuse hotline; and all three will report any knowledge or suspicion of abuse, abandonment, or neglect. At no time have any of the staff observed a co-worker telling a youth that they could not call the abuse hotline. One of the staff reported observing a co-worker using threats, intimidation, and humiliation when interacting with interacting with a youth. All three were able to report that once a youth completes a grievance form they would direct youth to location of the grievance box and asked them to place it in there.

The three youth surveyed all stated they are aware of the abuse hotline for reporting. At no time were they prevented from making phone calls to the abuse hotline and at no time were they ever denied clean clothing. When asked if youth could show or tell where the Abuse Hotline number is located, two out of the three were knowledgeable. One of the three youth indicated having made an attempt to call the abuse hotline.

No exceptions were noted for Indicator 1.02 as of the time of the QI visit.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

#### Rating Narrative

Agency has a clear and policy and procedure 1.03 for Incident Reports that meets the requirement of the indicator. The policy was reviewed and last updated on October 17, 2017.

Incidents are documented on an agency incident reporting form and placed in logs that capture pertinent information including: date, time, location; client status; participants/witnesses; individuals notified; corrective action and follow-up; and signatures of individuals who reviewed the incident. An incident reporting cover sheet that summarizes the incident is attached to the incident report form and emailed/faxed to the agency's Statewide Director of QA and Compliance for data entry. Staff receives training on CCC incident reporting during orientation.

The Agency has a CCC log book that shows the time and date that the CCC was called-in and whether the call was accepted or not. A total of 16 reported incidents of which 10 reports were accepted by CCC were reviewed. All reports were filled out appropriately and documented in the logbook. All contacts were made within the required 2-hour time-frame. In addition, there were also 4 case issues reviewed and they were explained in detail. All the reports were reviewed and signed off by the supervisor and follow-ups were listed on the reports.

There were no exceptions noted at the time of the QI review.

### 1.04 Training Requirements

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a very clear and precise policy and procedures that mirrors that of the Florida Network. It covers all the requirements of the QI Indicator 1.04. The policy was updated and reviewed last on October 27, 2017.

The agency maintains an individual training file for each staff which includes manually written training logs, supporting training certificates, sign in sheets, and agendas for each training attended. The agency has a full time employee to monitor and maintain the training files. All of the files reviewed were very neat and easy to navigate and information regarding training is easily accessible.

Four first year employee training files were reviewed for 1 part time and 2 full time Youth Care staff and 1 Non-residential Counselor. All four employees have exceeded the 80 hours annual required training hours.

Two of the four new staff completed all of the mandatory training required during the first 120 days of hire. There was no eligible non-licensed clinical shelter staff hired since the last onsite QI visit.

There were three in service training files reviewed; two of the three staff are on target for completing the 40 hours of training required annually and one has exceeded the required hours. All three staff demonstrated receipt of ongoing training and have completed the mandatory training topics required for in-service staff.

The program maintains well organized individual training files for each staff that includes an annual training log which documents required training, dates of completion, and number of hours completed. The file also includes documentation such as certificates, sign-in sheets, and agenda for each training. Training files are maintained by the Lead Program Assistant.

**Exception:**

Two of the first year staff, dates of hire 2/15/17 and 1/18/17, did not complete the Adolescent Youth Development training and one did not complete MAB training required to be completed during the first 120 days of hire. Upon notification during the QI visit, the two staff completed the Adolescent Youth Development training online and supporting documentation was submitted to the Reviewer.

**1.05 Analyzing and Reporting Information**

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedures 1.05 for Analyzing and Reporting Information which was last reviewed and approved 10/27/17. In addition, there is a comprehensive agency-wide Performance Quality Improvement (PQI) that includes detailed procedures to collect, review, and reports various sources of information to identify patterns and trends. Per the policy and procedures, the program collects and reviews several sources of information to identify patterns and trends including:

1. Quarterly case record review reports. These reviews may be completed by peers.
2. Quarterly review of incidents, accidents and grievances.
3. Annual review of customer satisfaction data.
4. Annual review of outcome data.
5. Monthly review of NetMIS data reports.

Findings are regularly reviewed by management and communicated to staff and stakeholders.

The program has procedures in place for analyzing and reporting data. Although P&P #1.05 does not outline the specific procedures, they are documented in the agency's PQI plan. The program assigns individual staff as Chairpersons to represent committees responsible for the collection of various data required by the indicator. A formal list was not maintained but the residential and non-residential program managers provided the names of the Chairs to the Reviewer onsite. The Chairs are responsible for collecting data from the programs on a monthly basis for Case Record reviews; Incidents, Accidents, and Grievances; Customer Satisfaction Surveys; and Outcome Data. Data received is entered into the agency's online database. NetMIS data is emailed to the management staff on a weekly basis for review and follow up. The data is compiled by the agency's CQI Director into reports that includes a summary of the 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. The program reviews the reports at monthly management and staff meetings. The Executive Director also posts outcomes data and corrective action plans on a board, which is accessible to staff, at the Administrative office.

**Quarterly Case Record Reviews**



The provider maintains a binder with monthly case record reviews for each program. A total of 205 cases were reviewed between July and December 2017. Documentation includes the checklists used during the peer record review for each file reviewed as well as a summary cover sheet that identifies deficiencies. Documentation of case record reviews was observed to be conducted on a monthly basis by the programs. A review of the agendas for monthly staff meetings held since July 2017 showed evidence of discussion of peer record reviews during staff meetings held during the review period.

#### Quarterly Review of Incidents, Accidents, and Grievances

Data regarding the number of incidents/accidents and grievances is entered into the agency's database that captures a variety of data for all of the programs statewide. A copy of the data entered for the review period was reviewed. A total of 103 incidents were reported by the residential CINS/FINS program from July-December 2017 of which 14 were classified as Level 1 incidents and 88 were classified as Level II incidents. Per the provider's procedures, incidents/accidents and grievances are reviewed at staff meetings. A review of the agendas for monthly staff meetings held since July 2017 showed evidence of discussion of incidents/accidents during the review period. The trends and types of incidents are discussed during the staff meetings.

The CINS/FINS residential program reported only 7 grievances during the review period. Grievances are tracked and documented on the SE Monthly Performance Outcomes Data Entry form that aggregates the data statewide. A review of the agendas for monthly staff meetings held since July 2017 showed evidence of discussion of grievances during the review period.

#### Customer Satisfaction Data

The programs collect customer satisfaction survey data monthly and enter the number completed each month into the agency's database. For the review period, a total of 105 customer satisfaction surveys were completed by the programs. A review of the agendas for monthly staff meetings held since July 2017 showed evidence of discussion of client satisfaction surveys during the six months reviewed.

#### Outcome Data

The provider has established program outcomes and collects data monthly on the PQI Monthly Spreadsheet Companion Report by program. Data collected includes benchmarks and performance measures such as: client satisfaction; client functioning; staff turnover; incidents/accidents; grievances; care days; training; exits; and follow ups. PQI, outcomes, and NetMIS data is reviewed and discussed at management meetings on a monthly basis and documented in the minutes.

#### NetMIS Data Review

Florida Network data is entered, tracked and documented in the agency's database. The data was reviewed onsite for the period July – December 2017. In addition, the Program Director shares this data with staff via emails. There is also evidence of this information being shared with program staff at staff meetings and the outcomes are posted for staff to view at the Administration office. A review of the agendas for monthly staff meetings held since July 2017 showed evidence of discussion of program improvement data during the six months reviewed.

There are no exceptions noted at the time of the QI review.

#### 1.06 Client Transportation

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy and procedure 1.06 for transportation of clients. This policy was last updated on October 27, 2017. The agency's policy addresses the following areas 1.) Approved agency drivers are agency staff approved by administrative personnel to drive clients in an agency approved private vehicle 2.) Approved agency drivers are documented as having a valid Florida driver's license and are covered

under company insurance policy 3.) Third party is an approved volunteer, agency staff, or other youth and 4.) Documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.

The agency is utilizing a transportation policy that requires all drivers to be background checked and possess a valid Florida driver's license. Approved drivers are covered by the agency's automobile insurance policy. The agency's transportation policy does allow single client transportation only when a third party is not available and there is prior approval by a manager. An approved volunteer, intern, agency staff, or other youth may be considered a 3rd party during a client transport. The agency's administrative staff reviews and approves all drivers for the agency and copies of all drivers' licenses are on file. Volunteers and interns are not allowed to drive agency vehicles but may be included in the staff to client ratio as it relates to transportation of clients.

Two sets of van logs were reviewed for the last six months. The log sheets include the drivers' names, date of travel, time, mileage, number of passengers, and destination in accordance with Florida Network standards. Out of the two van logs reviewed (blue & white vans), there were 34 single client transports found during period of July 2017 and December 2017. The agency was able to provide documentation verifying a total of 32 single client transport approvals by a supervisor. However there were incidents of transportation of youth from the JAC and youth referred by "ChildNet" in which these situations frequently did not provide a supervisor's approval.

**Exception:**

The agency is not strictly adhering to its stated policy for all single youth transports to have a signed supervisor's approval. This was evident predominantly in the transport of youth from JAC and ChildNet.

**1.07 Outreach Services**

Satisfactory

Limited

Failed

Rating Narrative

The agency has a very clear and precise policy and procedure 1.07 regarding outreach services that mirrors the Florida Network indicator. The policy and procedures reviewed were last updated on October 27, 2017.

The agency has a binder for maintaining inter-agency agreements that meet all contractual requirements. The agency also keeps a binder with outreach activities completed by the administrative or counseling staff. A separate binder contains meeting minutes for attendance to DJJ Circuit Meetings.

The agency has agreements with a variety of community partners including mental health, substance abuse, truancy, safe place sites, employment services, educational, medical services, and support services. During the review period, staff have participated in outreach activities in the community. All of these activities were used to share information about the agency's services. There was evidence of participation and attendance by the Shelter Manager or other designated staff to the Circuit 17 DJJ Advisory Board meetings. The program keeps copies of email notices of the meetings and received an agenda/sign-in sheet upon attendance. A separate binder contains meeting minutes for attendance to DJJ Circuit Meetings.

There were no exceptions noted at the time of the QI review.

## Standard 2: Intervention and Case Management

### Overview

#### Rating Narrative

Lutheran Services Florida Southeast is contracted with the Florida Network of youth and family services to provide both non-residential CINS/FINS and shelter services for youth and their families in Broward County. The program is designed to provide centralized intake and screening services twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year. Staff have been trained to evaluate the needs of youth and their families and make recommendations based on what services are most appropriate at the time of contact. Residential shelter services include, but are not limited to: case management, individual, family, and group counseling services. Referral services begin when the youth are admitted into shelter. Direct care staff is responsible for completing progress notes documenting the development of youth while in shelter, group counseling focused on a youths daily highs and lows experienced throughout the day, and providing daily supervision.

The program appears to have a functional centralized intake process in place. All direct care staff interviewed appear to be knowledgeable in providing CINS/FINS services and helping youth and their families work through crisis situations. Documentation reviewed contained detailed background information pertaining to a youth's initial assessment of immediate needs and presenting problems. Staff and supervisors appear to be proficient in gathering pertinent information to develop case/service plans and monitor progress throughout service delivery.

The non-residential component of Lutheran Services consists of a clinical supervisor and five (5) non-residential counselors (1 temporary position), all of which are funded by the Florida Network. There were no vacancies in the non-residential program as of the date of the onsite QI visit. Non-residential counselors are tasked with providing family counseling and case management services that link youth and families with services in the surrounding community.

Lutheran Services coordinates monthly Case Staffing Committee meetings in which a statutorily-mandated committee makes recommendations for treatment plans for youth that are runaway, ungovernable, truant, and lock out/homeless when other services have proven unsuccessful or per request from parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court.

### 2.01 Screening and Intake

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has written policies and procedures for Indicator 2.01 regarding their Screening and Intake Process. The policy manual was last updated on October 27, 2017 and was signed by the Executive Director, Clinical Director, and Residential Services Manager. The policy states that centralized intake services include screening for eligibility, crisis counseling and information, and referral. The screening for eligibility must occur within seven (7) calendar days of referral by a trained staff member using the NetMIS screening form. Youth and parent/guardians receive the following in writing during intake: available service options, rights and responsibilities of the youth and parents/guardians. Also available to youth and parents/guardians are possible actions occurring through involvement with CINS/FINS services (i.e. case staffing committee, CINS petition, and CINS adjudication) and grievance procedures.

An initial screening will be conducted either by phone or in person by a trained staff. Information regarding the youth's situation, presenting problem, immediate needs, and whether or not the youth is eligible for CINS/FINS services will be assessed and must be documented on the screening form. If it is assessed that an emergency does not exist; the youth may be placed on a waiting list.

1. Contact to the youth and family will begin within 7 days from receipt of phone call or any referrals for services.

2. **Non-residential:** upon acceptance for services a designated counselor will be assigned who will try to schedule CINS Intake, Suicide Risk Screening, and Brief FAM. Needs Assessment will be initiated within 72 hours of completing CINS/FINS Intake Assessment and complete within 2-3 sessions or visits.
3. **Residential:** upon acceptance for services, central staff will complete the full intake process with both the child and the family. The assigned counselor will then complete the NetMIS packet along with Risk Factors, and initiate the Needs Assessment within 72 hours.
4. All clients (residential and non-residential) are provided with information related to available service options, Rights and Responsibilities of youth and parents/guardians, possible actions occurring through involvement with CINS/FINS services, and grievance procedures. Families also receive a copy of the CINS/FINS handbook.
5. Verification that youth and family received aforementioned documents are confirmed by signatures of all parties involved to include the trained staff member, client, and parents/guardians.

Three (3) residential case files were reviewed. Of those files, one is currently active and two were terminated. All three (3) case files contained screenings that had been conducted within seven (7) calendar days of referral. All three (3) case files contain verification that client and parents/guardians were provided with information related to available service options, Rights and Responsibilities of youth and parents/guardians, possible actions occurring through involvement with CINS/FINS services, and grievance procedures. Families also received a copy of the CINS/FINS handbook. All three (3) case files had a CINS/FINS intake within an appropriate time-frame.

Three (3) non-residential case files were reviewed. Of those files, two are currently active and one was terminated. All three (3) case files contained screenings that had been conducted within seven (7) calendar days of referral. All three (3) case files contained verification that client and parents/guardians were provided with information related to available service options, Rights and Responsibilities of youth and parents/guardians, possible actions occurring through involvement with CINS/FINS services, and grievance procedures. Families also received a copy of the CINS/FINS handbook. All three (3) case files had a CINS/FINS intake within an appropriate time-frame.

No exceptions.

## 2.02 Needs Assessment

Satisfactory

Limited

Failed

### Rating Narrative

The agency has written policies and procedures for Indicator 2.02 regarding Needs Assessment. The policy manual was last updated on October 27, 2017 and was signed by the Executive Director, Clinical Director, and Residential Services Manager. The policy states that the Needs Assessment should be: 1) initiated or attempted within 72 hours of youth is admitted to residential or updated if most recent Needs Assessment is over six months old, or 2) completed within two (2) to three (3) in person contacts following the initial intake if the youth is receiving non-residential services or updated if most recent assessment is six months old. Needs Assessments are completed by Bachelor's or Master's level staff and signed by a supervisor.

1. Needs Assessment is initiated within 72 hours of admission for youth admitted to residential and is completed within 2-3 in person contacts following initial intake for youth receiving non-residential services or updated if most recent Needs Assessment is over six months old for both residential and non-residential youth.
2. Needs Assessment shall be completed by Bachelor's or Master's level staff and include a supervisor's review signature upon completion.
3. Youth identified as having suicide risk behaviors during the Needs Assessment shall be referred for an Assessment of Suicide Risk conducted by or under direct supervision of a Licensed Mental Health Professional.

Three (3) residential case files were reviewed. Of those files, two (2) were terminated and one (1) is currently active. One of three residential case files observed did not have a Needs Assessment initiated within 72 hours of admission.

Three (3) non-residential case files were reviewed. Of those files, two are currently active and one was terminated. All three (3) non-residential files contained Needs Assessments that were initiated within 72 hours of admission.

All 6 case files were completed by a BA or MS level staff member. All 6 case files had a supervisory review signature.

None of the case files reviewed were identified as having an elevated risk of suicide or Baker Act.

Exception:

One of the three residential files observed did not have a Needs Assessment initiated within the 72 hours of admission. The assessment was observed to be 4 days late.

### 2.03 Case/Service Plan

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has written policies and procedures for Indicator 2.03 regarding Case/Service Plan. The policy manual was last updated on October 27, 2017 and was signed by the Executive Director, Clinical Director, and Residential Services Manager. The policy states that the case plan is developed within seven (7) working days following the completion of the assessment and based on information gathered from the initial screening, intake, and assessment.

The provider's procedure includes the following:

1. Implementation of case/service plan that is developed within seven (7) working days.
2. Case/Service Plan reviews conducted by the counselor and parents/guardians (if applicable) every 30 days for the first three (3) months and every six (6) months thereafter.
3. Case/Service Plan includes identified need(s) and goal(s), person(s) responsible, type, frequency, and location of service(s), target date(s) of completion, actual completion date(s), signature of youth, parents/guardians, counselor, and supervisor as well as date plan was initiated.

Three (3) residential case files were reviewed. Of those files, two (2) were terminated and one (1) is currently active. All three files contained case plans that were observed to be developed and implemented within 7 working days. All three cases were individualized and prioritized the client's need(s) and goal(s) that were identified during the Needs Assessment. All three case/service plans contained person's responsible, type, and frequency, and location of service(s). All three case/service plans contained the dates that they were initiated. All three case/service plans contained signature of youth, parents/guardians, counselor, and supervisor. Two case/service plans contained target dates of completion. Two case/service plans contained actual dates of completion while one file did not contain date(s) of completion due to goals/objectives not yet being resolved. Two service plans did contain a 30-day review while one case/service plans did not require a 30-day review.

Three (3) non-residential case files were reviewed. Of those files, two are currently active and one was terminated. All 3 case files contained case/service plans that were observed to be developed and implemented within 7 working days. All three case files were individualized and prioritized to the client's need(s) need(s) and goal(s) that were identified during the Needs Assessment. All three case/service plans contained person's responsible, type, and frequency, and location of service(s). All three case/service plans contained the dates that they were initiated. All three case/service plans contained signature of youth, parents/guardians, counselor, and supervisor. Three case/service plans contained target dates of completion. One case/service plan contained actual dates of completion while two case/service plans did

not contain date(s) of completion due to goals/objectives not yet being resolved. One service plan did contain a 30-day review while two case/service plans did not require a 30-day review.

**Exception:**

One of the three residential case service plans reviewed was observed to be missing target dates for completion of objectives.

**2.04 Case Management and Service Delivery**

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policies and procedures for Indicator 2.04 regarding their Case Management and Service Delivery. The policy manual was last updated on October 27, 2017 and was signed by the Executive Director, Clinical Director, and Residential Services Manager. Their policy states that each youth is assigned a counselor/case manager who will follow the youth's case and deliver services through provision or direct referral.

The provider's procedures include the following:

1. Each youth is assigned a counselor/case manager who will follow the youth's case and deliver services through provision or direct referral.
2. The process of case management includes but is not limited to: establishing referral needs and coordinating referrals to services based on the on-going assessment of the child's/family problems and needs, coordinating service plan implementation, monitoring youth's/family progress in services, providing support for families, monitoring out of home placement, if necessary, referrals to case staffing committee as needed, recommending and pursuing judicial intervention in selected cases, accompanying youth and parent/guardian to court hearings and related appointments, if applicable, referral to additional services, continued case monitoring and review including court orders, and case termination follow up.

Three (3) residential case files were reviewed. Of those files, two (2) were terminated and one (1) is currently active. All three cases had a counselor assigned. All three cases did require referrals that were noted. Three files did not require monitoring out-of-home placement due to all three being placed at the shelter. All three case files demonstrated that staff monitored youth/family progress and showed evidence that family received support. Two of three cases had been terminated. Of the two terminated cases, one contained 30 and 60 day follow ups after exit. One of the files was not eligible for 30 or 60 day follow ups as youth is still active within the Shelter.

Three (3) non-residential case files were reviewed. Of those files, two are currently active and one was terminated. All three cases had a counselor assigned. All three cases did require referrals that were noted. Three files did not require monitoring out-of-home placement due to all three being placed at the shelter. All three case files demonstrated that staff monitored youth/family progress and showed evidence that family received support. One file contained 30 and 60 day follow ups after exit. Two of the files were not eligible for 30 or 60 days follow ups as the youth are still receiving CBC services.

No exceptions.

**2.05 Counseling Services**

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policies and procedures for Indicator 2.05 regarding Counseling Services. The policy manual was last updated on October 27, 2017 and was signed by the Executive Director, Clinical Director, and Residential Services Manager. The policy states that youth and families receive counseling services in accordance with youth's case/service plan to address needs identified during the assessment process. Shelter program provides individual and family counseling, as well as group counseling sessions held a minimum of five days per week. Non-residential provide CBC services to provide interventions to stabilize family in the event of crisis, keep families intact, and minimize out-of-home placement, provide aftercare services for youth returning home from the shelter, and prevent involvement in the dependency system.

The program has the following procedures:

1. All referrals are screened for eligibility and if deemed eligible will begin the CINS/FINS intake process in order to review suicide risk or reasons for referral.
2. Non-residential: Youth can be referred for residential if it is determined that a child and family need a brief "cooling off/respice".
3. All full time non-residential staff will carry an annual case load of 69 cases and must have a minimum of 12 sessions.
4. Staff must maintain chronological notes, maintain individual case files on all files, ensure suicide risk is monitored through delivery, and maintain internal processes that ensures clinical reviews of case records, client management and staff performance.

Three (3) residential case files were reviewed. Of those files, two (2) were terminated and one (1) is currently active. All three case files received individual and family counseling services in accordance with their case/service plan. All three files contained notes that were maintained chronologically with progress being documented. All cases did receive group counseling, however, only a few notes were presented within each file. All three cases provided documentation that clinical reviews of case records were conducted.

Three (3) non-residential case files were reviewed. Of those files, two are currently active and one was terminated. All three files were appropriately screened appropriately to determine youth's eligibility for the CINS/FINS intake process. All three case files received individual and family counseling services in accordance with their case/service plan. All three files contained notes that were maintained chronologically with progress being documented. Group sessions did not apply to this population. All three cases provided documentation that clinical reviews of case records were conducted. One file contained documentation that youth had been referred to Lutheran's shelter for respice care.

**Exception:**

All three residential files were documented to be receiving group counseling. However, implementation of group at least 5 days per week was inconsistent per agency group logbook. Agency has implemented a Corrected Action Plan dated 1/8/17 for missed groups.

## 2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy governing the Adjudication and Petition process (2.06). This policy was last reviewed and revised on 9/18/2015.

The procedure for this policy illustrates the expectations to maintain a case staffing committee and convene as necessary in order to provide families with services or treatment. Per the provider's procedures, a case staffing committee is held if:

- The family or child is not in agreement with the services or treatment offered

- The parents or child will not participate in the services or treatment selected
- The case manager needs additional assistance in developing a case plan.

If a parent/guardian requests a case staffing committee meeting it must be in writing and the staffing must be held within 7 working days of receipt of the written request. A case staffing will be scheduled if the family or youth have not demonstrated substantial progress in achieving goals and/or if the services selected have not addressed the problems and needs of the family. The youth and family will be notified by phone or in writing within 5 days of the case staffing meeting being scheduled.

The program's Case staffing meetings occur monthly and additional meetings may be held if, requested, including emergency case staffing. The outcomes and documentation of results of case staffing committee meetings is maintained in each client's file and reviewed monthly by the Prevention/Intervention Manager. Clients receive copies of all documents that they sign or documents pertinent to their case. Written requests are sent to CINS/FINS director and/or their designee. Committee members are notified by the director or designee. If a parental case staffing request is not scheduled within the guidelines due to unforeseen circumstances it is the responsibility of the CINS/FINS director or designee to provide an explanation in writing and schedule the meeting the next soonest available date. Within 7 days of the CSC meeting recommendations must be provided in writing to parent/guardian. A copy is also placed in client file. The assigned case manager or designee will make every effort to meet with client and family within 7 days of the CSC meeting to review recommendations and establish and/or update service plan.

One applicable open non-residential case file was reviewed. The case file listed the staff as the individual initiating the case staffing. Evidence supported that the family was notified of the case staffing within 5 working days and notification was also provided to the committee within the appropriate time frame. Parties present at the case staffing included: a local school district representative, a DJJ representative and/or CINS/FINS provider, and a mental health representative. A written report was provided to the parent/guardian immediately following the staffing, outlining the committee's recommendations and reasons.

**Exception:**

There was no documentation in the file indicating that the youth/family were provided a new or revised plan for services as a result of the case staffing.

**2.07 Youth Records**

Satisfactory                       Limited                       Failed

Rating Narrative

The agency has a written policy and procedure, 2.07 Youth Records, that addresses all of the key elements of the CQI indicator. The policy was last reviewed and approved 10/27/17 and was signed by the executive director, the clinical director and the residential services manager.

The provider's procedure includes the following requirements: all case files are marked confidential; each client case record hall includes chronological sheet and youth demographic data, program information, correspondence, service/treatment plans, needs information, case management information and other materials relevant to the case; all files are kept behind a locked door in a file cabinet that is marked confidential; upon discharge the files are signed by a program manager and maintain in a locked file room in the file cabinets marked confidential; files are maintain by the lead program assistant for a period of two years then transferred to a central storage unit and maintained for a period of 7 years; and all files are maintained in neat and orderly manner.

A total of seven files reviewed during the visit were clearly marked confidential. The case files are kept in a secured room in a locked cabinet in the Counselor/Intern's office at the shelter and in a locked file room at the Administrative office. The file cabinets are also marked "confidential".

If/when cases are transported by staff, they are transported in an opaque, lock box marked confidential.



**The opaque container is equipped with a combination lock for security purposes.**

**All records reviewed onsite were found to be maintained in a neat and orderly manner.**

**No exceptions.**

## Standard 3: Shelter Care

### Overview

#### Rating Narrative

LSF Southeast operates its residential program, Lippman Youth Shelter, licensed by DCF through 6/27/2018 for 20 beds. The shelter provides residential services to youth in the Department of Juvenile Justice (DJJ) CINS/FINS program. At the time of the review, the shelter was providing services to 7 CINS/FINS youth. Lippman shelter is also designated as a provider of staff secure, probation and domestic violence respite services, and domestic minor sex trafficking services for youth. The ED indicated that due to zoning issues, the program cannot take youth who are pending DJJ charges. During the review period, the program did not serve any probation respite, domestic minor sex trafficking, or staff secure youth.

The Lippman Youth Shelter has one dormitory wing separated by a hallway. Half of the bedrooms are used for male clients and the other half for females. Youth are separated based on census needs. An individual room close to the staff desk is utilized for clients with special alerts. The facility also has a large common area used for watching television, groups and other activities. The dormitory, kitchen, restrooms and common areas were clean during the tour of the facility. The program has adequate space for all activities and is equipped with a new 25 camera system that allows complete surveillance in and around the outside of the building.

Youth are assigned closets that lock to store their personal belongings. Beds are lettered and youth are assigned to individual beds furnished with bed coverings and pillows. Youth have access to a large yard for outdoor activities. The youth admitted to the program are screened using the Network Youth Screening Form and the CINS/FINS Intake Form.

Clinical services are supervised by a licensed Clinical Supervisor. Services provided include individual, group and/or family counseling, and any other applicable intervention required. The youth admitted to the program are screened using the Network Management Information System (NetMIS) Youth Screening Form, the CINS/FINS Intake Form, and a brief FAM (Family) General Scale. If a youth answers "yes" to any of the six questions pertaining to suicide risk on the CINS/FINS Intake form or if the staff member's observations of the youth's behavior would indicate any area of concern, an Assessment of Suicide Risk (ASR) is completed. The ASR is completed by either licensed professional or a non-licensed counselor under the direct supervision of the LMHC. A medical and mental health alert system is in place and the shelter staff that administers medications have been trained in the distribution of medication.

### 3.01 Shelter Environment

Satisfactory

Limited

Failed

#### Rating Narrative

Agency has a written policy and procedures that meets all required elements listed in the Florida Network Standards for Indicator 3.01. The policy was reviewed last on 9/11/2015, revised 9/21/2015 and signed by the Executive Director on 10/27/2017.

Health and fire safety inspections are to be conducted annually. Shelter furnishings are to be kept in good repair for aesthetic reasons and to ensure safety in the use of those furnishings. The shelter building and grounds are to be treated at least once each quarter by a professional pest control company. The shelter exterior is to be maintained as required seasonally by a professional landscaping company. Bathrooms and shower areas are to be inspected by shelter staff at least once on each shift. All rooms are to be inspected for contraband and graffiti a minimum of once each day.

At admissions each youth is to be assigned their own bed, pillow and bed linen. Each room is to have sufficient lighting for reading or to perform other tasks in shelter. Youth may request that any personal belongings be kept in a locked place. Those belongings are to be placed in a plastic bag with the youth's name attached to it and locked in a file cabinet located in the Youth Care's Office.

The agency has a twenty bed facility with four bedrooms for males and four for females and one alert bedroom for youth who may require their own room based on history. Each bedroom has two to three beds inside except the alert bedroom which has one bed. Male bedroom number 9 has three beds and female bedrooms number five and seven has three beds. According to the Shelter Manager, the facility is a thirty-two year old building and has recently been through Hurricane Irma in September of 2017 but fared very well. During the tour and walk-through, it was observed that furnishing was in good condition in the common area for the clients. It was also observed that in bedroom number four or five in the female section, a screen from the window has to be placed back on the window. The program was free of insect infestation. Grounds were landscaped and well maintained in the front and back of the building. Also grounds were free of any hazards and exterior was free of debris. All five bathrooms and showers in agency were functional and clean. In the youth bedrooms each bed was covered with mattresses, clean linen, blankets, and pillows. No graffiti was found on premises. Lighting in the shelter common area, bedrooms, bathrooms, kitchen and staff offices were adequate for tasks to be performed on daily basis. Garbage bins were stored nicely on the side of the shelter and were covered with lids. All staff and agency vehicles were securely locked. Agency vehicle (Blue Mini Van) observed was equipped with first aid kit, fire extinguisher-recently stamped on January 2018 by Fire Department, glass breaker, and seat belt cutter.

Agency has a detailed map and egress plan of the facility located in client bedrooms in a binder and posted in the common area. An egress plan/map is also located in front of the Shelter Manager's Office. Agency also has grievance forms located adjacent to the client common area along with a locked box which the Shelter Manager oversees. In the agency's common area, DJJ hotline telephone number, DCF abuse hotline number, and other related notices are posted. During the QI review it was observed that interior bedrooms were free of contraband and free from hazardous unauthorized metal/foreign objects. Bedrooms contained a closet for each client and a room to store their property and clothing.

Agency has a MSDS chemical checklist and chemicals were stored in a locked storage bin outside in the back of shelter. Agency maintains key control compliance by having staff sign in and out for keys on a daily sign in/out form and on a shift change checklist on a daily basis. Agency has maintained all items in the storage bin matched with chemicals listed on checklist. Staff has checked chemical list with items on monthly basis: Last checks were 1/5/2018, 12/31/2017, and 12/20/2017. Agency has in and out access limited to staff members with key cards to enter the building. Each shelter staff has master keys to open bedrooms, bathrooms, laundry room, and kitchen. Staff completes shift exchange staffing form which states how many keys each employee has on shift.

Agency has current DCF License certificate provided as of June 28, 2017. The agency has an annual facility fire inspection that was conducted by Oakland Park Fire Rescue on 5/1/2017 and there were two violations for Chapter 7: means of egress, and emergency light repair/replace. The agency needed to get an emergency light backup power to replace batteries in front of counseling room. Another violation was Chapter 10 General safety requirements - Owner/Occupant responsibility to maintain systems and testing paperwork. Action required was that any person in control of the building or premises shall keep records of all systems and testing reports. Also another action required was that agency had to provide a copy and maintain current documentation of fire suppression records. On 6/5/2017, the Oakland Park Fire Rescue revisited and the agency was cleared for those previous violations.

Agency has a current satisfactory Residential group care inspection as of July 31, 2017 where the State of Florida Department of Health conducted an inspection for the facility including a food inspection. Agency has maintained cold food properly stored in refrigerators and pantry. Agency had three violations but all had been addressed as of the onsite visit. Violations were: ceiling finish in disrepair next to window in room 6, peeling paint on wall next to light switch, observed bathroom missing soap, paper towels in room 8, and missing fitted sheets on mattress in room 9/bed B.

All fire safety equipment inspections are valid and up to date regarding kitchen overhead hood, sprinklers, alarm system (inspection on January 2, 2018). Agency completes fire drills on a weekly basis which is more than what's required. The agency also conducts mock emergency drills on a weekly basis although standard and policy requires on quarterly basis.

Youth are engaged in meaningful structured activities. Agency has daily scheduled activities posted in the

common area in which youth participates seven days a week. There is a week day schedule and weekend schedule provided to the youth. Youth are involved in educational, recreational, life, counseling, and social skill training during awake hours. Agency also utilizes backyard of shelter for outside activities such as basketball, boxing, and free time outside. Youth also are allowed to participate in faith based activity. Agency has also had activities for the youth such as “interview for success”, “Master Chef Cook Off”, a quarterly make over day, and staff vs. youth events. Youth are able to complete homework after school and have access to program approved books which is in a locked cabinet in the common area.

**Exceptions:**

Agency vehicle (Blue Mini Van) was missing air bag deflator and flashlight during QI inspection. During site visit air deflator was purchased and placed in agency vehicles.

The following observations were made during inspection of the facility:

- Dining area light fixture covering is cracked.
- In kitchen, cabinet next to stove was burned and along-side of cabinet needs to be cleaned from grease/food build-up. (During site visit, staff cleaned and scraped cabinet which contained food/grease build up.)
- Silver refrigerator needs cleaning and labeling of dates on food was not consistent. (During site visit Shelter Manger reported trashing the unlabeled items in refrigerator.)
- In Laundry area, a wall trowel tool with sharp edges was found accessible to clients. (Shelter manager was informed and tool was placed in a secure area.)

**3.02 Program Orientation**

Satisfactory                       Limited                       Failed

Rating Narrative

The agency has a written policy and procedure that meets all required elements listed in the Florida Network standards for Indicator 3.02. The policies were reviewed on 11/9/2014, and revised 9/21/2015. Policy and procedures are signed on an annual basis and last updated on October 27, 2017.

The agency has developed procedures related to admissions, interviewing and room assignment to ensure the safety of all youth placed in the residential facility by completing initial assessment which determines the most appropriate room assignment based on the youth’s needs. Each youth receives a detailed orientation handbook at time of intake along with orientation checklist within 24 hours.

Three residential files were reviewed and all clients received program orientation within 24 hours of admissions that included receiving a comprehensive orientation handbook, disciplinary action explained, grievance procedure explained, emergency/disaster procedures, contraband rules, physical facility layout map, room assignment, and suicide prevention alert notification. All three files had parent/guardian and youth signature obtained on all intake documents. During orientation, client signs client rights and responsibilities; daily activities are reviewed and the abuse hotline number is provided.

No exceptions noted.

**3.03 Youth Room Assignment**

Satisfactory                       Limited                       Failed

Rating Narrative

The agency has a written policy and procedure that meets all required elements listed in the Florida

Network standards for Indicator 3.03. The policies were reviewed on 11/7/2014, and revised 9/21/2015. Policy and procedures are signed on an annual basis and last updated on October 27, 2017.

Agency staff evaluates clients at the intake process for the purpose of room or living assignment with consideration given in potential safety and security concerns. Staff review available information about youth's history, status and exposure to trauma, separation of younger youth from older youth, separation of violent youth from non-violent youth, identification of youth susceptible to victimization, presence of medical, mental or physical disabilities, suicide risk, and sexual aggression and predatory behavior.

Three residential files were reviewed (one closed and two open files). During intake process, all CINS/FINS intake assessment forms were completed where room assignments were listed. Each youth was assessed and initial classification information such as age, gender, disabilities, history, and gang affiliation was determined by staff completing screening forms and CINS/FINS intake form. Each youth had alerts which were noted on the alert board and on the front of the file folder. All intakes are completed by staff initially for placement and followed up with an assessment by the counselor. Two out of the three files, youth answered yes on one of the six risk screening questions and all youth had sight and sound observations conducted and followed up by suicide assessment with counselor. After assessment by counselor, it was determined that youth did not need to be placed in the special alert bedroom.

No exceptions noted.

### 3.04 Log Books

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy and procedure that meets all required elements listed in the Florida Network standards for Indicator 3.04. The policies were reviewed on 11/7/2014, and revised 10/24/2017. Policy and procedures are signed on an annual basis and last updated on October 27, 2017.

Agency has been utilizing an electronic log book approximately one year now to document routine daily activities, and events and incidents in the program. Logbook entries are reviewed by direct care staff and supervisory staff at the beginning of each shift. Electronic log book must include entries that could impact the security and safety of the youth and/or program which are highlighted. All entries should include date and time of incident, event or activity, names of youth and staff involved, a statement providing pertinent information, and the names and signature of the person making the entry. Agency should strike line through all errors in recording in the log book. The program Director should review the log book every week and make notes indicating the dates reviewed and if any correction, recommendations and follow ups are required along with signature/date of entry. All oncoming supervisor and direct care staff should review log book of previous two shifts to be aware of any unusual occurrences, and problems.

Log book was reviewed from 7/1/2017 through 7/8/2017 and 12/1/2017 through present. As the agency is using the electronic log book, all entries are legibly written due to being typed. From the review of the log book it was reflected that the agency was completing the requirements by documenting safety and security issues, documenting incidents with youth and staff name, date, time, and signature. Errors are struck through with clear line with staff initial and date. Staff also documented late entries. Supervisor also documented reviews conducted in red, with signature and date. Supervisor/Shelter Manager conducted reviews on a daily basis instead of weekly basis to be aware of situations in shelter. Supervisors and staff reviewed logbook as they entered their shift. Log book also included documentation for fire drills, new intakes, and discharges. Physical head counts are documented and highlighted in yellow and bed checks are noted every 15 minutes. All daily activities were also noted such as eating, conducting hygiene, youth in common area under supervision, and visits with client names involved.

Exceptions:

Some staff did not specify if they reviewed the logbook during a certain time frame and it was not clear if staff reviewed previous two shifts.

On 12/1/2017, an overnight staff failed to log out of shift at 7 am.

### 3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy and procedure that meets all required elements listed in the Florida Network standards for Indicator 3.05. The policies were reviewed on 11/7/2014, and revised 9/21/2015. Policy and procedures are signed on an annual basis and last updated on October 27, 2017.

The agency has a behavioral management strategy that is designed to not only gain compliance with program rules, but to change the behavior of the youth and increase accountability. The program has a detailed written description of the behavioral management strategies. The program has variety of rewards, appropriate consequences, and behavioral management system which is based on a token economy of points and phases and is used to encourage youth to decrease or eliminate negative behaviors and increase positive behaviors.

During the tour and interview with Supervisor, it was observed that the program has a point system of incentives on client board on which staff places check marks for Good Deeds and Loss of Privileges. Youth receives points for goals achieved while in shelter such as following rules, daily chores, on time for meals, respect towards staff and peers, etc. Agency has level phases one through three for behaviors. On Phase one: a youth can have the privilege to stay up an extra thirty minutes at bedtime and an extra phone call per week. Phase two: youth can go on phase 2 outings, two extra phone calls and stay up an extra hour at bed time. Finally, Phase three: youth can receive three extra phone calls per week and stay up an extra hour and half at bed time. Youth also write down coping skills, for example when they are angry, to help them manage their behaviors. Agency has an orientation process that is explained to youth regarding the behavioral management system and discipline policies which is signed on the client rights form.

Four new hire files were reviewed and it was observed that all had training on the behavioral management system. Staff maintains binder and completes a shift note which reflects the youth points on a daily basis. Per interview with youth, it was mentioned that during orientation, the Behavioral Management Systems and point system were explained. Youth was aware of what phase, good deeds, and level was given by staff based on behaviors.

No exceptions noted.

### 3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a policy for governing Staffing and Youth Supervision, #3.06. This policy was last reviewed and revised on 9/21/2015. This policy addresses staffing requirements, supervision intervals, and practice for maintaining adequate staff to provider for 24 hour, awake supervision at all times.

This policy is to be implemented by maintaining minimum staffing ratios of 1 approved staff to 6 youth during waking hours, and 1 approved staff to 12 youth during sleep hours. A minimum of 2 staff are to be on duty at any time, and staffing should reflect both a male and female staff present for each shift. The schedule should be posted in an area available to all staff or provided to them directly. An on-call list is maintained of approved auxiliary staff available for coverage as needed. Staff must maintain a frequency of 15 minute bed checks while youth are in their sleeping rooms, or during illness which confines youth to

their sleeping quarters. Program staff includes youth care workers, supervision staff, and treatment staff.

The program maintains an up-to date roster of approved full, part-time, and on-call youth care workers available for shift coverage. The printed schedule is available in the staff area of the common room where most of the activity and monitoring occurs. A survey of schedules for the past 6 months indicates some substitutions in coverage, but an otherwise consistent regular work force assigned to specific shifts. The program has two vacancies at the moment—one full-time and one part-time, for which they are actively seeking to fill. All shifts reviewed had both female and male staff on the floor with youth.

Review of the bed-check logs indicates a consistent practice of 15 minute bed-checks. Four shifts were randomly selected to match the log book entries to the video time-stamps. In all 4 shifts the coverage and documentation were consistent. Dates reviewed were: 1/11/2018, 1/09/2018, 1/7/2018, and 12/1/2018.

No exceptions noted for this indicator.

### 3.07 Special Populations

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy and procedure that meets all required elements listed in the Florida Network standards for Indicator 3.07. The policies were reviewed on 11/20/2014, and revised 9/21/2015. Policy and procedures are signed on an annual basis and last updated on October 27, 2017.

Agency has policy and procedures for all special populations such as Staff secure, Domestic Minor Sex Trafficking, Domestic Violence Respite, and Probation Respite. Staff secure services are designed to serve court ordered youth who have been held in contempt of court for continued running away or are locked out of their home due to history of conflict and/or ungovernable behavior. Staff secure placements provides more intensive staffing and individualized services. Staff secure has procedures pertaining to referrals, transfers, placement, and staff secure shelter services.

Domestic Violence Respite services are designed to serve youth that have been arrested on a domestic violence charge, are screened by the local detention center/screeners, and do not meet detention criteria and cannot immediately return home. Domestic violence placement is short term and cannot remain in shelter more twenty (21) days and are available to both male and female youth ranging from ages 10 years and up to 18 years of age who have been charged with an offense of domestic violence.

At the time of the review, the agency had served only domestic violence special population cases since the last QI review. Three closed residential Domestic Violence Respite files were reviewed. Delinquency face sheets were provided in files for evidence that youth were admitted DV Respite placement pending DV charges and have been screened by the JAC/Detention but do not meet criteria for secure detention. All three youth did not exceed the length of stay of 21 days for placement. No approval documentation was needed for all three cases due to youth not exceeding the 21 days in shelter and did not have to transfer into CINS/FINS bed or Probation Respite. All case plans/treatment plan reflected goals which focused on coping skills to manage anger, family coping skills, and other interventions design to reduce re-occurrence of violence in the home. All three files reviewed were consistent with the same services required for CINS/FINS population.

No exceptions noted.

### 3.08 Video Surveillance System

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a policy #3.08 governing the use of a video monitoring system that is in operation 24 hours a day, 7 days a week. The primary stated purpose of the policy is to provide accountability for staff

and provide a visual record of events within the milieu. The policy was last revised on 10/24/2017.

The procedure requires that the system maintain the following capabilities:

1. Capture and retain images for a minimum of 30 days.
2. Record date, time, and location.
3. Maintain a resolution able to identify faces.
4. Cover all general areas, but not sleeping rooms or rest rooms.
5. Only accessible to designated personnel.
6. Bi-weekly supervisory review and noted in the logbook.
7. Reviews assess a random sample of overnight shifts.
8. All cameras are visible and a notice is provided that they are in use.
9. Ability to provide selected video to third party requests.

The program director provided instruction and access to the video monitoring system. Specific dates and times were reviewed to confirm documentation of bed checks and sight and sound log monitoring. In all instances the staff were viewed conducting the checks as recorded.

The video system maintains a saved record of 30 days, confirmed by review of the footage recorded 30 days prior to this review. The program has a written list of personnel approved to review video footage posted in the director's office. A separate log is maintained to document supervisory review of video for a random sample of shifts. This log indicates that program management is conducting supervisory reviews at a greater than required frequency.

Program Director demonstrated the proficiency to capture, save, and export a segment for third party review upon request.

No exceptions noted.



## Standard 4: Mental Health/Health Services

### Overview

#### Rating Narrative

The Lippman Youth Shelter 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 bed 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 Clinical Supervisor and Program Manager are notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented on Alert System Form that is maintained in a binder and is accessible to all staff.

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 Pyxis Med-Station 4000 Medication Cabinet located in the medication room. Over-the-counter (OTC) medications are maintained in another locked cabinet located in the medication room and documented in the OTC medication log. 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 MDR Binder.

LSF SE Lippman staff were available for follow-up and requests. All documents were provided in advance or upon request for the following indicators. In general, Standard 4 covers very serious and critical processes within the program environment (the management and tracking of youth medications, the monitoring of youth at risk of suicide, medically fragile, or otherwise in crisis, and screening for physical health concerns both acute and chronic.) The review of both policy and practice indicate that the program under review is utilizing all available resources to provide safeguards against the significant potential consequences to these indicators. The exceptions or findings identified in the following review reflect a normal pattern within a 24 hour crisis environment. Program personnel were open to feedback regarding these findings and demonstrated a respect for the Quality Improvement Review process.

### 4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a policy governing Healthcare Admissions Screening titled 4.01. The policy was last reviewed on 8/24/2016. No changes were made.

The procedure for physical health screening requires all youth to be evaluated at time of admission. If the facility nurse is present they are required to conduct the physical screening of clients. If the nurse is not present non-healthcare staff may perform this screening. In the event the nurse is not present for the screening they must review all physical health screenings within 5 business days of initial intake. The screening procedure is a questionnaire regarding acute and chronic medical conditions, past and existing allergies, recent injury or illness, presence of pain or physical distress. Observations for evidence of injury, illness, physical distress, or difficulty moving are documented. Observations and inquiry are also

made for the presence of scars, tattoos, or other skin markings.

Physical health screenings are conducted as part of initial intake in 3 of 3 files. Screenings conducted in these files were conducted by non-healthcare staff.

**Exception:**

There is no documentation for Nurse review of physical health screenings. The process was described by interview, but no written evidence to support the practice was presented.

**4.02 Suicide Prevention**

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy governing the requirements and practice for the screening, assessment, and supervision of youth to prevent and intervene in attempted suicide by youth placed in emergency shelter. The policy contains a written plan that details the suicide prevention and response procedures in accordance with the Florida Network's Policy and Procedure manual for CINS/FINS services. The policy was last reviewed on 9/2/2015 and subsequently updated on 9/17/2015.

Each youth is screened for suicide risk beginning with the initial screening tool that precedes any youth being admitted to shelter. If the youth is reported as actively suicidal they are referred to call 911. All youth accepted for intake are screened for risk of suicide during the initial face-to-face interview with the client. This secondary level of screening may result in immediate referral to emergency services, or the youth receiving a heightened level of supervision. All youth who indicate a positive response to the suicide screening questions at intake must be evaluated by a licensed mental health professional within 72 hours and are placed on constant sight-and-sound supervision until cleared by the licensed mental health professional. This professional utilizes an approved tool for evaluation of suicide risk to make a determination that the youth is not at risk, or if necessary make a referral where a higher degree of supervision and care can be provided.

Three residential files were reviewed (1 open and 2 closed). Practice indicates the program is in compliance with all contracted obligations for the screening and response to youth at risk of suicide. All screenings and assessments were conducted according to the required time frames and utilizing the approved tools. The screening results were reviewed and signed by the supervisor and documented in the youth's case file in all 3 files. Similarly, the youth were placed on sight and sound supervision until assessed and removed by the licensed professional. Observation logs indicate 30 minute supervision intervals by designated staff.

**Exception:**

In two (2) separate files, with (2) separate shift supervisors the sight-and-sound log has signatures approving a column with no time entries or initials from staff.

**4.03 Medications**

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedures that address the safe and secure storage, access, inventory, disposal, and administration/distribution of medications. It was revised on September 21, 2015.

The program has a list of thirteen staff members currently employed that complete the required training and has been authorized to assist in the distribution of medication when the nurse is not on site. Youth medications are verified by the shift leader and a pharmacist at intake. Medications are stored in a Pyxis

**Med-Station 4000 Medication Cabinet located in the medication room. Over-the-counter (OTC) medications are maintained in another locked cabinet located in the medication room and documented in the OTC medication log.**

**The program has a part-time licensed registered nurse (RN) that started on January 12, 2016. She distributes medications when she is on site. A tour of the program, staff interviews, and documentation reviewed reveals that all medication in the shelter are securely stored in the locked medication room inaccessible to youth.**

**Thirteen staff members are assigned as Super Users for the Med-Station. All staff surveyed indicated that they assist youth in the delivery of medication, and that they are informed of medication side effects and the medical alert system. Oral medications are stored separately from injectable and topical medications.**

**Narcotics and controlled medications are stored behind two locks and documented in the medication distribution log. A perpetual inventory with running balances is maintained. All the youth's Medication Distribution Logs (MDLs) reviewed, displays all the required information. The program has a small refrigerator which was used only to store medication that was empty at the time of the review. There were no syringes and sharps at the program during the time of the review. The program has a Medication Disposal Binder and a Medication Disposal Form, but shows no medication has been disposed since 2012.**

**Under item 13 in the policy referencing the delivery process of medications, the Florida Network (FNYFS) is referenced as FMYS, a possible typo.**

**Exceptions:**

**When youth is discharged, patient-owned OTC meds are removed from the Pyxis and stored in separate cabinet until parent/guardian collects them. Although securely stored, there is no official inventory of this medication.**

**There is no documentation (email) of automated reports from Knowledge Portal.**

**The current policy has a reference to staff being required to carry the key to the locked medication cabinet. This appears to be old language from a previous policy version.**

**4.04 Medical/Mental Health Alert Process**

Satisfactory

Limited

Failed

Rating Narrative

**The program has a policy governing the Medical and Mental Health Alert process. This policy was last reviewed on 9/21/2015. The policy is designed to identify medical conditions, mental health concerns, as well as other factors that require awareness for successful supervision and care for youth. This alert process maintains continuity from intake to discharge informing the staff by means of the log book, a dietary and food allergy board in the kitchen, and documentation inside the front cover of the client's file.**

**The procedure for this policy requires all staff to be trained in the alert system and to take required action to place youth under heightened supervision if there is a concern for client safety. The current coding system identifies the following alerts: Medical condition, Sight and Sound Supervision, Allergies, Substance Abuse, Mental Health, Physically Aggressive, and Chronic Runaway. Staff are notified of alerts via a board posted in the shelter manager's office where the staff exchange keys upon arrival and departure. There is a key posted with it indicating a color code system and identifying what each color dot represents. The alerts posted on this board were congruent with the alerts posted on the youth files.**

**Three youth files, 1 open and 2 closed, were reviewed. All three files were identified with one or more alerts and were appropriately placed on the program's alert system. Medication alerts included the necessary precautions concerning the prescribed medications. These were documented on the alert sheet in the client's file. Adequate information was also document on the alert sheet regarding instructions to effectively respond to the need for emergency care for medical/mental health problems.**

The coding system in the written policy does not match the system in place on the youth files and alert board. In the policy Chronic Runaway is identified by a pink dot, but in the current practice it is identified by a yellow dot. Policy requires updating.

No exceptions noted for this indicator.

#### 4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

##### Rating Narrative

The program has a policy governing Episodic and Emergency Care (4.05). This policy was last reviewed on 9/21/2015. The policy dictates procedures for obtaining off-site emergency services and the subsequent reporting and aftercare responsibilities.

The procedure requires all staff to be trained and certified in first aid and CPR within 6 months of beginning work with youth. The program maintains 2 extensively supplied first aid kits and a knife for life and wire cutters at the central staff station. Emergency medical response and poison control phone numbers are displayed in the central area.

There have been 6 medical incidents during this review period. In 3 instances, the youth were verified as returned to the program following the incident. The other three were not marked as returned or not. Upon inquiry, the program director verified that all youth were returned to shelter. This verification was made by review of internal incident reports and confirmed in the log book.

No exceptions noted for this indicator.