



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of LSF NW- Currie House

on 03/14/2019

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

Percent of indicators rated Satisfactory:100.00%

Percent of indicators rated Limited:0.00%

Percent of indicators rated Failed:0.00%

Standard 3: Shelter Care

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

Percent of indicators rated Satisfactory:87.50%

Percent of indicators rated Limited:12.50%

Percent of indicators rated Failed:0.00%

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity/Expression	Satisfactory

Percent of indicators rated Satisfactory:100.00%

Percent of indicators rated Limited:0.00%

Percent of indicators rated Failed:0.00%

Standard 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:96.43%

Percent of indicators rated Limited:3.57%

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

Keith Carr, Lead Reviewer, FOREFRONT/Florida Network of Youth and Family Services

Lea Herring, Regional Monitor, Florida Department of Juvenile Justice

Sabriena Williams, Residential Supervisor, CDS Behavioral Health Services

Mark Shearon, Chief Compliance Officer, Arnette House

Mahogany Brown, Residential Program Manager, CCYS

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 type="checkbox"/> Program Director | <input checked="" type="checkbox"/> Program Manager |
| <input 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 type="checkbox"/> Clinical Director | <input checked="" type="checkbox"/> Counselor Licensed | <input type="checkbox"/> Counselor Non- Licensed |
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Advocate | <input checked="" type="checkbox"/> Human Resources |
| <input checked="" type="checkbox"/> Nurse | | |
| 3 Case Managers | 1 Maintenance Personnel | 3 Clinical Staff |
| 0 Program Supervisors | 1 Food Service Personnel | 4 Other |
| 1 Health Care Staff | | |

Documents Reviewed

- | | | |
|---|--|--|
| <input checked="" type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input 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 | 6 # Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 6 # MH/SA Records |
| <input checked="" type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 18 # Personnel Records |
| <input checked="" type="checkbox"/> Contract Scope of Services | <input type="checkbox"/> Precautionary Observation Logs | 10 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 4 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 10 # Youth Records (Open) |
| <input checked="" type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | 4 # Other |

Surveys

5 Youth 6 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 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

The SNAP Program has gotten off to a flying start. At last, the program has found a home base at the Brownsville Community Center where they can leave their program supplies and not have to carry them to a location every time they meet. Six Facilitators are on board along with the Site Coordinator and Case Manager. They have done an amazing amount of outreach including community events and being a part of the Integration Meeting which consists of agencies from all over the county meeting to discuss issues in Escambia County. The current focus is the opioid crisis. The Brownsville Community Center is currently asking SNAP to be a part of their summer program. SNAP has just acquired an intern.

This year has presented us with staffing challenges in both shelter personnel and clinical personnel. We are proud to say that the clinical positions have all been filled and the shelter positions are close to being filled. That being said, we have had a lot of people with a learning curve. That is always a challenge, but we have risen to that challenge.

We hired a Life Skills Coach who is working with our shelter clients teaching them skills that will benefit them in life. She also helps with street outreach.

Dozer, the therapy dog that has visited Currie House every month for a number of years has retired, but his nephew Sir Davis is in training and we hope to see him soon.

Currie House is now using the upgraded version of NoteActive and has acquired new tablets.

Currie House takes the clients on outings regularly, but this past summer they took a day trip to the Florida Caverns at Mariana. The clients had a wonderful time!. They have also visited a local historical site, the Arcadia Mill in Milton, and learned some of the history of northwest Florida.

The clinical staff has made a connection with the Escambia School District to receive mental health referrals.

In June we tested our hurricane preparedness with our annual Hurricane Drill. Hurricane Martin hit hard, but prepared us for the aftermath of Hurricane Michael where we took clients from HOPE House so that they could host the evacuees from Panama City.

Standard 1: Management Accountability

Overview

Narrative

Lutheran Services Northwest (LSF-NW) is contracted by the Florida Network of Youth and Family Services to provide CINS/FINS services in the Northwest region of the Florida Panhandle. This youth shelter operates 24 hours a day, 365 days a year and serves from six (6) youth up to a maximum of twelve (12) CINS/FINS shelter beds in each program. The agency as a whole provides a broad range of service offerings to those youth and families in need through Outreach efforts in their immediate service region. The agency's primary focus is providing residential and non-residential CINS/FINS services to youth and families in short-term crisis situations. The agency has numerous interagency partnership agreements with local community stakeholders and partners. Public, private and non-profit organizations and partners include local schools, law enforcement, United Way, local area businesses, faith-based organizations, medical partners, homeless shelters, and various other community-based organizations.

1.01 Background Screening

Satisfactory
 Limited
 Failed

Rating Narrative

The program currently has a policy in place addressing the background screening process for hiring an employee or utilizing the services of a volunteer, mentor, or intern. The program's policy states employees and volunteers are re-screened every five years of employment and the Annual Affidavit of Compliance with Good Moral Character Standards is to be completed and sent to the Department's Background Screening Unit annually by January 31st. This policy was reviewed and signed by the Regional Director on September 18, 2018.

LSF-NW conducts Live Scan Background Screening on all potential employees and volunteers prior to any offer of employment, granting of volunteer status, and/or any direct contact or participation in agency activities may occur. A rescreening of each active employee is completed every five years after the date of the initial screening. All Youth Care staff applicants complete a pre-employment assessment on the Predictive Index website.

Seventeen employees have been hired since the program's last annual compliance review. The program has recently adopted a pre-assessment tool, Predictive Index, categorizing employees into four different pattern insights, formality, extraversion, patience, and dominance. The program is aware that the pre-assessment tool was implemented by July 1, 2018 for all direct care staff. There is evidence that the program has used this tool with one of the seventeen new employees.

Seventeen records were reviewed for background screening and sixteen out of seventeen of the records had their background screenings completed with an eligible rating prior to their hire date. One staff was previously employed with the program and had less than a month break in service before returning as an employee, so the program completed a new local background criminal check and maintained the original background screening with an eligible rating.

One staff member qualified for a five-year rescreening. Her original hire date was June 10, 2014 and the re-screening was completed on March 12, 2019 with an eligible rating.

The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the background screening unit (BSU) on January 9, 2019.

No exceptions were noted for this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory
 Limited
 Failed

Rating Narrative

The program currently has a policy to provide an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. Program staff are to adhere to a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation. This policy addresses that any person who knows or suspects a child is abused, abandoned, or neglected by a parent, legal custodian, or caregiver, must report this knowledge to the Florida Abuse Hotline. This policy was reviewed and signed by the Regional Director on September 5, 2018.

The program has a Code of Conduct located in the Lutheran Services Florida Personnel Policies and Procedures Manual, Section 1.0-Statements of Mission and Philosophy. When an employee is hired, he/she signs a form stating they have read these behavioral expectations and agree to comply with them. The program has an accessible and responsive grievance process for youth to provide feedback and address complaints. The program also has the Florida Abuse Hotline number posted throughout the building.

The program has a code of conduct where staff signs a form stating that they have read these behavioral expectations and agree to comply with them. This form is maintained in the employees' personnel files. Staff are trained in child abuse reporting and management does take immediate action to address any incident involving physical and/or psychological abuse, verbal intimidation, use of profanity, and/or use of force. The youth have access to the grievance forms in the common area but do not have access to a dropbox to place their grievances in without the assistance of the staff per policy. The program does maintain a record of any calls made to the abuse hotline. The program's supervisor or clinical supervisor handles the complaint/grievance documents.

This indicator has a preliminary rating of satisfactory with only one exception. The policy states the program will have a box for the youth to place a grievance in without the assistance from the staff. At this time, the program does not have a box, and the youth turn the grievance into a staff.

Per the staff survey results, 4 out of 6 staff confirmed they hand the grievance to the Supervisor.

1.03 Incident Reporting

Satisfactory
 Limited
 Failed

Rating Narrative

The program has a policy in place for when a reportable incident occurs, the Department of Juvenile Justice (DJJ) Central Communication Center (CCC) is notified within two hours or within two hours of becoming aware of the incident. This policy includes the Department of Children and Families (DCF) /FamiliesFirst Network (FFN) Incident reporting as well. This policy was signed by the Regional Director on September 5, 2018.

The policy documents the phone numbers for all Departments, timeframes, the definitions of DJJ reportable incidents, medical incidents, mental health and substance abuse incidents, complaints against staff incidents, youth behavior incidents, and definitions of reportable DCF/FFN incidents.

Ten incidents have been reported to the Department of Juvenile Justice's Central Communication Center (CCC) within the past six months. All ten incidents were reported no later than two hours of the program learning about the incident and the follow-up communication was completed by the program as required by the CCC. All ten reports were completed on incident reporting forms and reviewed and signed by the program's supervisor. Nine out of ten of the reports were documented in the electronic logbook.

No exceptions were noted for this indicator.

1.04 Training Requirements

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a training policy that has been reviewed and approved by the regional director, Beth Decker on 9/5/18. The policy identifies a detailed list of trainings and time frame that are required to be completed by the agency staff.

The policy states that within the first year of hire all staff who are providing CINS/FINS services are required to obtain 80 hours of training and 40 hours per year thereafter. It is also indicated that in policy that all new hires must complete new hire orientation in addition to specific program training.

In the policy there is a detailed list of trainings to be completed within 120 days of hire, a list of trainings to be completed within the first year, as well as a list of trainings to be completed in DJJ SkillPro.

The reviewer reviewed 10 staff training files, (6) of which were new hire staff within the 120-day window and (4) that have been employed for a

longer period of time, (2) of which have been employed 1 or more years and (2) that has been employed for 6 months or longer. The files contain a training log showing the current number of training hours, trainings that have been completed, in addition to, training sign-in sheets and certificates of completed training.

During the examination of the 6 new hires (5) of them had not completed all of the new hire training, however, it was concluded that they will have until mid to end April to have all trainings completed. Whereas, one of the new hires has completed all of the required trainings except for (1) that is a requirement within 120 days of hire.

While reviewing staff training files it was noted that there was (1) person that had an expired CPR certification. After speaking with management it is believed that the person in question has an updated certification but yet to turn it in and will be added to the roster for the next CPR training course otherwise.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program currently has a policy that states they will collect and review several sources of information to identify patterns and trends. This policy was signed by the Regional Director on September 5, 2018.

The program reviews quarterly case record review reports, incidents, accidents, grievances, annual review of customer satisfaction data and outcome data, and monthly review of NetMIS data reports.

According to the program, they had one hundred percent at the end of the first and second quarter on their thirty and sixty-day follow-ups. Service completion remains about the same and date entry is at one hundred percent for both quarters. Care days for both quarters are far below where they need to be, however, the trend is improving, now at eighty-four percent. Non-residential admits are currently at eighty-three percent, but should start to improve since the program has become fully staffed. The quarterly case record reviews stay one hundred percent for both shelter and non-residential. According to the program, incidents, accidents, and grievances have been at a manageable number. Medication incidents have been identified as a weakness and have been watched closely. They are currently at about the halfway point to where they were last year for the total and so the drive is to keep them low to the end of the year with few than last year. The program stated that care days are increasing and are currently a strength for them, as well as all of the clinical position being recently filled. From the available data, customer satisfaction is at ninety-five percent for shelter and ninety-eight satisfaction for non-residential services.

No exceptions were noted for this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place for client transportation. The policy is established to avoid situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth. This policy was signed by the Regional Director and approved by September 5, 2018.

The program's approved agency drivers must have a valid Florida driver's license and are covered under LSF insurance, documentation of use of vehicle that notes name or initials of driver, date and time, mileage, and number of passengers, purpose of travel and location, staff must be approved by administrative personnel to drive youth in agency or approved private vehicle, and a third party is an approved volunteer, intern, agency staff, or other youth.

The program's transportation policy states that drivers must be approved by administrative personnel, maintain a valid Florida driver's license, and are covered under LSF insurance. However, the policy is not written that they prohibit transporting a client without maintaining at least one other passenger. The procedure states that a third party may be an approved volunteer, intern, agency staff, or other youth, and in the case where a third party is unavailable, the agency's supervisor will consider the youth's history, evaluation, and recent behavior who is being transported. The supervisor must be made aware prior to transport and consent is documented for a single driver to transport a single client. Staff must document names or initials of driver, date and time, mileage, number of passengers, the purpose of travel, and location.

A review of the agency's current transportation process regarding the transport of all eligible residents admitted to the program was reviewed for adherence to contract requirements.

At the time of this program review, the agency does have a transportation policy and process that includes authorized drivers that are approved by the agency's management personnel. The policy does require the agency to contact management when at least one passenger is in the vehicle with a staff person.

The agency does have staff persons that are approved to drive and all have active valid Florida driver's licenses and are covered by the

required limits of insurance protection. The policy does include provisions that allow the agency to make decisions in the event that a third-party is not present in the vehicle during the transportation event. Further, the agency's policy requires its managers to consider the clients' history, current evaluation, and behavior in the event that a third-party cannot be obtained to join a single driver transporting a single resident. A review of transportation events conducted by the agency over the past 4 to 6 months indicates there is evidence that staff are requesting approval prior to transport and the supervisor's approval is documented in the logbook accordingly. All of the aforementioned transportation events use official agency vehicles, staff document the event as required and include names occupants dates, times, mileage, the purpose of the travel event and location.

No exceptions were noted for this indicator.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The program currently has a policy in place stating they participate in local Department of Juvenile Justice board and council meetings to ensure CINS/FINS services are represented in a coordinated approach to increasing public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services. The policy was signed by the Regional Director on September 5, 2018.

The agency has a planned Outreach program. The Regional Director, Clinical Director, Service Managers and Outreach Team develop partnership agreements with specific prevention outreach goals, objectives and outcomes as a part of these plans. This service is performed by an outreach coordinator or outreach specialists assigned to this specific function

The prevention/outreach strategy focuses on educating youth and families on the dangers of running away, and informing them about community resources available to them in times of crisis. The agency's Prevention/Outreach efforts target at-risk, runaway and homeless youth and their families as well as the community at-large.

The program informs the community of its services through community presentations and printed materials. Printed materials include agency brochures and other program marketing tools.

The agency requires designated staff to participate in local and circuit level DJJ board and council meetings to inform and ensure others participants that CINS/FINS services prevent or reduce juvenile delinquency through effective prevention, intervention and treatment services. The Outreach Coordinator is required to attend meetings and these meetings, advocates for the effective use of CINS/FINS services, and updates agency leadership on meeting activities.

Outreach service efforts are delivered by designated staff throughout the following counties that include Escambia, Santa Rosa, Okaloosa, and Walton Counties. The target audience includes runaway and homeless youth and their families, as well as the community at large. Efforts are made through school presentations, community presentations, fundraisers, distribution of materials, community events, and other methods.

The program's lead staff member discussed several different examples of community events that they participate in. The focus was on four specific events, EscaRosa Suicide Prevention Coalition, Circuit 1 Human Trafficking Task Force, Escambia County Juvenile Justice Council, and Homeless "Sleep Out". The program provided minutes for all four of these events and had other verification that showed a representative from the agency attended. The program does maintain a binder with inter-agency written agreements.

No exceptions were noted for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The LSF-NW agency provides residential and non-residential services to youth ages 6 - 17. The agency's Non-Residential program is under the direct supervision of a Licensed Mental Health Counselor (LMHC). At the time of this onsite program review, the agency LMHC supervises an all Master's Level counseling team of Counselors that primarily provide counseling services to clients in Pensacola/Escambia County service region. The Non-Residential program services client needs across additional counties that include Santa Rosa, Okaloosa, and Walton. Several of these counties are in rural and outlying areas. The agency provides several services. The referrals for services are received from parents, school, counselors, the court system, youth, and other sources. The services provided by LSF-NW includes individual, family and group counseling along with case management services. Case management services include life skills, social skills, and referrals for services upon the youth's return to the home/community. The youth also receive referrals for substance abuse and mental health services.

2.01 Screening and Intake

Satisfactory Limited Failed

Rating Narrative

Agency has a current Screening and Intake policy. The policy states that centralized intakes are completed within 24 hours seven days a week. Intakes include screening for eligibility, crisis, counseling, and information and referral. The Regional Director and Clinical Director reviewed the policy on 9/5/18. It was reviewed by the Quality Services Manager on 9/6/18. The policy adheres to and meets the general requirements of the indicator.

The Counselor, YCS and or other assigned staff, are using the procedure and practices within 24 hours. The agency uses this procedure to ensure that twenty - hour access to services are met to meet the needs of families. The Agencies procedures are that screening for eligibility is to begin within seven working days. All of these procedures are met as defined by the standard.

This reviewer assessed a sample of six (6) client files serviced by the agency within the last 6 months. Of these client case files, three (3) were residential and 3 were non-residential. Of the files reviewed, all 6 client files had documentation that the agency initiated contact with the clients to request screening within the seven (7) day requirement. Youth and parents received information regarding the available service options and their rights and responsibilities. All 6 files reviewed showed evidence that they received information on the grievance procedures and possible actions related to the case staffing committee, CINS adjudication process, and CINS petition.

No exceptions are documented for this indicator.

2.02 Needs Assessment

Satisfactory Limited Failed

Rating Narrative

Agency has a current policy on Needs Assessments. The policy states that the needs assessment is completed to gather information for all youth receiving services.

The Needs Assessment must be initiated or attempted with 72 hours of admission and completed within two to three face to face contacts following the initial intake if the youth is receiving non-residential services. The Needs assessments are completed by Bachelor's or Master's level staff and signed by a Supervisor. The Counselor completes the Needs Assessment to gather and analyze information. The Needs assessment must be initiated within 72 hours of admission and conducted by the counselor or case manager. Needs Assessments are conducted by a Bachelor's or Master's level staff.

This reviewer assessed a sample of six (6) client files serviced by the agency within the last 6 months. Of these client case files, three (3) were

residential and 3 were non-residential. Of the files reviewed, all 6 client files had documentation that the agency initiated a needs assessment within the 72 hour timeframe and it was completed two to three face to face for non- residential services.

All files reviewed were conducted by a Bachelor or Master level staff member and include the Supervisor signature upon review of completion.

2 of 6 files reviewed indicated youth identified with an elevated risk of suicide and were referred appropriately for an assessment of suicide risk under the direct supervision or conducted by a licensed mental health professional.

No exceptions are documented for this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

Agency has a current Case / Service Plan policy. The policy states that a plan is developed with the youth and family within 7 working days following the completion of the assessment. The plan is based on information during the initial screening, intake, and assessment.

The Case/ Service plan is developed with the referring youth and his/her family within 7 working days following the completion of the assessment. The plan is based on the information derived from the screening, intake, and assessment.

This reviewer assessed a sample of six (6) client files serviced by the agency within the last 6 months. Of these client case files, three (3) were residential and 3 were non-residential. Of the files reviewed, all 6 client files had documentation that the agency developed a case plan within the seven working days and gathered all the information needed to complete a developed case plan. The parents were involved and it was reviewed every 30 days and every six months thereafter. All 6 files reviewed, contained a service plan that met all the requirements including; service type and frequency, persons responsible, target dates for completion, actual completion dates, and signatures of youth and parent.

No exceptions are documented for this indicator.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

Agency has a current Case Management and Service Delivery policy. The policy states that each youth is assigned a counselor/case manager who will follow the youth's case and ensure the delivery of services through direct provision or referral.

The Counselors are using the procedure and practices. The agency uses this procedure to ensure that each youth are assigned a counselor/ case manager to obtain services while in Shelter and Non-Residential Care. All of these procedures are met as defined by the standard.

This reviewer assessed a sample of six (6) client files serviced by the agency within the last 6 months. Of these client case files, three (3) were residential and 3 were non-residential. Of the files reviewed, all 6 client files were assigned a Counselor/ Case Manager, referral needs were met, coordinating services were implemented, progress of services were documented, family support was defined, case staffing were done, referrals for additional services we indicated as well as case termination and follow-up.

No exceptions are documented for this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

Agency has a current Counseling Services policy. The policy states that youth and families will receive counseling services, in accordance with the youth's case/service plan, to address needs identified during the assessment process. Shelter programs provide individual and family

counseling, as well as group counseling services.

The Counselor/ Case Manager is using the procedure and practices. The agency uses this procedure to ensure that individual, group, and family counseling services are being rendered to all youth and families. Residential services are providing individual, group and family, while Non-Residential are receiving individual and family support.

This reviewer assessed a sample of six (6) client files serviced by the agency within the last 6 months. Of these client case files, three (3) were residential and 3 were non-residential. Of the files reviewed, all 6 client files had documentation that individual, group and family counseling was being conducted and youth and families had the opportunity to participate in counseling services while in residential care. Non Residential youth and families received therapeutic community-based services designed to provide support outside of a residential setting.

Group counseling sessions consist of at least 30-minute sessions with a clear leader or facilitator and allow for the opportunity for youth engagement.

No exceptions are documented for this indicator.

2.06 Adjudication/Petition Process

Satisfactory
 Limited
 Failed

Rating Narrative

Agency has a current Adjudication / Petition Process policy. The policy states a case staffing committee is scheduled to review the case of any youth or family that the program determines is in need of services or treatment. A case staffing committee is convened within 7 days request from the parent/guardian or any other member of the committee

Per the agency's procedure, as a result of a case staffing committee, the youth and their families are provided with a new or revised plan of service. Within 7 working days of the case staff meeting, a written request is provided to the family outlining the committee's recommendations. The program works closely with the judicial intervention for the youth or family in accordance with the procedures outlined in the Florida Statue and the Florida Network's Policy and Procedure Manual for CINS/FINS.

This reviewer interviewed Sherry Swann, Clinical Supervisor, and Counselor Ebony and they indicated that two Counselors attend the Truancy Court hearings at Truancy Court weekly. The Judge will give the staff a list of youth who are ordered for shelter services and the duration they are being ordered to stay. The screening process is then made with the parents/guardians on-site and the process of bringing the youth into the shelter is implemented.

The youth are case staffed each week. The Case Manager/Counselor completes a review summary prior to the reviewing hearing, informing the court of the youth's behavior and compliance with court orders and provides recommendations for further actions to be implemented.

The agency had no examples of adjudicated youth or youth meeting the case petition criteria during the time of the review, therefore, the agency is in compliance at this time.

No exceptions are documented for this indicator.

2.07 Youth Records

Satisfactory
 Limited
 Failed

Rating Narrative

Agency has a current Youth Records policy. The policy states that Youth Records are maintained confidential for each youth that contains pertinent information involving the youth and his/ her treatment at the program.

All records are marked " confidential and kept in a secure room or locked in a file cabinet that is marked confidential, which is accessible to program staff. All records that are transported are in a locked container. Youth records are maintained in a neat and orderly manner so that staff can quickly and easily access information.

This reviewer assessed a sample of six (6) client files serviced by the agency within the last 6 months. Of these client case files, three (3) were residential and 3 were non-residential. Of the files reviewed, all 6 client files were marked "confidential". All records in the record room were securely kept in a secure or locked file cabinet marked " confidential". Reviewer saw one locked marked container marked " confidential". All records are maintained in a neat and orderly manner.

No exceptions are documented for this indicator.

2.08 Sexual Orientation, Gender Identity/Expression

Satisfactory

Limited

Failed

Rating Narrative

Agency has a current Sexual Orientation, identity, Gender Expression policy. All youth are provided a safe environment and therapeutic case planning regardless of the youth's actual or perceived sexual orientation, gender identity or gender expression.

The Counselor, YCS and or other assigned staff, are using the procedure and practices to ensure that all youth are respected, safe and from persecution based on their actual or perceived sexual orientation.

This reviewer interviewed Sherri Swann, the Clinical Supervisor, and she indicated that the staff was informed of the new policy at a scheduled staff meeting within the last 6 months. There has not been any youth who identifies with this policy within the last 6 months. The shelter has some signage on the front administration door and one sign in the staff office at the shelter.

No signage was observed in the youth area in the shelter area. It is recommended that more signage be placed throughout the shelter to create a more inviting atmosphere for the identified population.

Per the survey, 4 out 5 staff report that they are to refer to youth by the name and pronoun they prefer. 1 staff indicated they are to refer to the youth by the name on their birth certificate.

No exceptions are documented for this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The LSF-NW Currie House youth shelter provides temporary respite residential services to youth ages 6-17 in the Department of Juvenile Justice (DJJ) CINS/FINS program, as well as for youth from the Department of Children and Families DCF. The shelter program management team is comprised of a Youth Care Specialist (YCS) III Residential Shelter Manager. The Regional Director and Shelter Manager oversees the operations and duties at two (2) shelters in Pensacola and Crestview, providing oversight and supervision of the direct care workers that are responsible for the CINS/FINS residential and non-residential programs as well as other programs operated by the provider in the Northwest Region. Each shift also has a YCS that is the designated team leader. The residential youth shelter building includes a large day room, individual girls' and boys' sleeping rooms, individual bathrooms, kitchen, laundry, residential and counseling staff offices. The building also has a separate medication and camera room and the exterior of the office includes a large back yard with a small basketball court and recreation area. The Youth Care Specialist (YCS) staff are responsible for completing all applicable admission paperwork, conducting youth orientation to the shelter, and providing necessary supervision. Health and medication related activities are the responsibility of the staff. Additionally, Currie House residential youth shelter is designated by the Florida Network of Youth and Family Services to provide staff secure services and other special populations. Specifically, this shelter is designated by the Florida Network to provide staff secure services, Domestic Violence (DV) respite, Probation Respite, and Domestic Minor Sex Trafficking.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

This Agency has very clear policy in place that meets all contractual requirements and was last reviewed and signed by the Regional Director on 9/5/18.

The Agency clearly lays out in its Procedures that the Shelter Environment will be clean, free of insects, plumbing in good working order, grounds clean, and Agency will be inspected by local authorities and licensed by Department of Children and Families.

The Agency was last re-licensed by on Sept. 28th, 2018, the local Fire Marshall Inspection was March 8th, 2018, the Residential Group Care Inspection was on December 4th, 2018, the Fire Equipment was tested on August 17th, 2018.

Upon walking around the facility it was clean free of graffiti. All appliances are in working order. All lights are operational. Exit lights and Emergency lights are operational. Furnishings are in good repair. The exterior grounds of the shelter appear to be well maintained, free of hazards, and debris. It was observed that a tiny insect that resembling bedbugs was seen, however, the agency contacted the pest control company during the onsite visits and it was confirmed it was not bedbugs. The program was free of insect infestation at the time of the review.

The Agency has Daily Schedules for Monday through Friday and one also for Saturday and Sunday. The schedule offers the youth with faith-based time, opportunities to read and do homework, and opportunities for physical activities.

Documentation reviewed evidenced that the agency had the following inspections current and up-to-date: DCF License 9/28/2018, Fire Marshall Inspection 3/8/2019, Residential Group Care 12/4/18, and fire safety equipment inspection 8/17/2018.

There are no exceptions in this area.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The Agency has a very clear Policy in place that meets all contractual requirements.

During the Intake Process, the Orientation process is critical to a successful stay. The Youth Care Staff develop a rapport with the youth and provide effective orientation for the youth. Orientation is conducted individually with the youth immediately following the screening and assessment part of the intake. Staff specifically and deliberately review each of the key intake and orientation issues and clarifies any questions that might arise.

There were 8 files (3 closed files and 4 open youth files) that were reviewed for this indicator.

All 8 out of 8 files showed evidence that during the 1st 24 hours following admission the orientation process with youth includes youth receiving

a program handbook and a signature of youth with the guardian is obtained. Additionally, the program provides the abuse hotline number and reviews daily activity.

After the Intake process, each youth is issued a detailed Youth Handbook in which the Grievance process, Emergency Disaster, Contraband rules, House rules, Chore assignments, and weekly schedules. The phone call schedule is discussed as well as visitation schedules.

There are no exceptions in this area.

3.03 Youth Room Assignment

Satisfactory
 Limited
 Failed

Rating Narrative

The Agency has very clear Policy that meets all contractual requirements for this indicator.

During the Intake process the Youth Care Specialist collects required information on each youth coming into the Shelter. The staff makes an initial decision based on the youth's physical characteristics, maturity level, history of trauma, gang or criminal involvement, potential for aggression, and apparent physical, medical, emotional and/or mental issues.

The shelter intake assessment form collects all the initial classification of the youth including through its review the youth's history, status and exposure to trauma; as well as the youth's: age, gender, history of violence, disabilities, physical size/strength, any identified gang affiliation, suicide risk, and sexually aggressive behavior. With this information, the staff assigns rooms to the youth and starts any alerts that are required. The Agency has updated this intake form on 3/19 to show the collection of Gender Identification, however, all the youth charts reviewed were using the older forms that did not collect that information.

9 out of 9 files reviewed did not indicate that the program documented the youth's gender identification during the intake process. The agency does have an updated form to capture this information, however, this shelter did not appear to be utilizing it at the time.

3.04 Log Books

Satisfactory
 Limited
 Failed

Rating Narrative

The Agency has a clear policy that meets all contractual requirements for this indicator. The policy was last reviewed by the Regional Director on 9/5/18.

The Agency maintains a daily log that documents general program operational information. Important or critical information is highlighted. A color-coded index is used to specify certain events.

All required information per this indicator is documented in the electronic logbook.

The Agency uses a color-coding system in the electronic logbook that includes yellow is very important info, blue is intake/discharges, and pink is important info.

All staff sign-in and log out on the logbook, as well as notify the have passed keys down and reviewed previous shifts.

The Shelter Manager reviews the logbook weekly and makes entries to reflect that highlighted in yellow.

There are no exceptions noted for this indicator.

3.05 Behavior Management Strategies

Satisfactory
 Limited
 Failed

Rating Narrative

The Agency has clear policy in place that meets all contractual requirements for this indication. The policy was last reviewed by the Regional Director on 9/5/18.

The BMS fosters accountability for one's behavior and compliance with the program's rules and expectations. All staff will be trained in the BMS and in turn, will teach the youth how to use the program. The supervisors will be trained in how to monitor the program and provide feedback on

the use of rewards and consequences.

Five staff training files were reviewed and all five had evidence of being trained on the BMS. The program is clearly laid out in the Youth Handbook given to each youth at intake.

The BMS uses a wide variety of awards/ incentives to encourage participation including; TV, movies, video games, etc.. Consequences are logical and designed to promote skill-building.

The Agency has a protocol in place to provide feedback and evaluate staff on their use of the BMS rewards and consequences.

There are no noted exceptions to this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The Agency has clear Policy that meets all contractual requirements for this indicator. The policy was last reviewed by the Regional Director on 9/5/18.

The Agency has staff coverage schedule that provides adequate supervision of youth and ensures the safety and security of all youth and staff.

Agency has a clear schedule posted in the Staff office and meets all Florida Administration Code for the 1 to 6 daytime ratio and the 1 to 12 ratio for sleep hours. The Agency has surveillance cameras and record at least 30 days.

There were 126 total shifts reviewed for this indicator. 48 out of the 126 shifts did not have male and female staff coverage to meet youth census. This reviewer did not receive documentation of credible proof of effort to evidence when these circumstances could not be met by the male and female staff requirements.

There were three days of random overnights reviewed with one hour period of time.

All checks were within the required amount of time.

Of the 126 shifts reviewed, 48 shifts did not have the male and female staff covering the shift. During the previous year's QI visit, the Agency had an exception for having staff coverage by two females only and not the required one female and one male per contractual requirements. The Agency continues to struggle in this area for meeting the male and female staff ratio.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

Agency has a clear policy reflecting all the Contractual requirements for this indicator. This policy was last reviewed by the Regional Director on 9/5/18.

The policy clearly states how youth are determined eligibility for each of the Special population areas and how the Treatment Plan will be developed for each area and the length of stay for each area.

The Agency has policies in place to meet the requirements for serving youth meeting the criteria for staff secure, domestic violence respite, probation respite, ICMS, FYRAC, and domestic minor sex trafficking youth. The Agency reports to the writer that they have not served any Staff Secure, Domestic Minor Sex Trafficking, Probation Respite, or Intensive Case Management youth during this review period.

They have only served one youth that meets the DV respite criteria and that youth is currently in Shelter.

After reviewing that youth's file, all required documentation is in place. Youths Treatment plan reflects all required goals and youth is working towards those goals.

There are no noted exceptions to this indicator.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

The Agency has a very clear Policy in place that meets all contractual requirements for this indicator. The policy was last reviewed by the Regional Director on 9/5/18.

The camera system is in place to ensure the safety of the staff and youth and to deter behaviors. The system is placed in all public areas and records 24 hrs a day. The supervisor will review the cameras at least once every 14 days and will keep a log of these reviews. The system will allow for a third party review in the event of a problem.

The Agency has updated its camera system within this review period and the system is now able to save video recording now for at least 30 days. All cameras appear visible, are located in the interior and exterior of the facility and there is a notice posted on the premises to make visitors aware of the video security.

The supervisor reviews the video at least every 14 days and records her findings in a separate logbook. The video was reviewed to ensure bed checks were being conducted in the appropriate time frame and this was apparent by the video. The supervisor is very familiar with the workings of the system and navigated it with ease.

The Agency has a list of designated staff that can access the video surveillance system the Director, Shelter Manager, and 2 other designated staff.

There are no exceptions noted for this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

LSF-NW operates both the Currie House and Hope House residential youth shelters. Their residential and non-residential CINS/FINS Programs are located in Escambia, Santa Rosa, Okaloosa County, Florida and are also the designated CINS/FINS provider for both Escambia and Santa Rosa Counties. The program has a management team that is comprised of the following positions: North Region Director; Clinical Director that is a licensed Mental Health Counselor; Residential and Non-Residential Counselors; a Youth Care Specialist III-Residential Services Manager; Residential Direct Care Staff, Outreach Coordinator; Administrative and Maintenance staff. At the time of the onsite QI visit, the agency reports that staff turnover is an issue. The agency has experienced a high degree of turn-over of YCS shelter staff across all shifts since the last QI program review.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a detailed policy on Healthcare Admission Screening. A review of the agency's current policy was conducted on site and the current policy was found to have met general requirements to adhere to FNYFS policy and quality assurance standards. The current Lutheran Services Florida residential and non-residential policy specifically lists examples of major health and medical conditions to include diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries which occurred during the previous two (2) weeks, acute allergies, chronic bronchitis or other chronic disorders. The agency's health screening form addresses all elements of the indicator.

The agency initiates and performs the health screening process during the healthcare screening process. The FNYFS CINS/FINS Intake Form is one of the primary tools utilized by the program to screen for the current status of acute health conditions. The agency requires that the CINS/FINS Intake Form is utilized to screen each youth for a broad range of health and medical conditions. Further, the screening form is used to determine the existence of past, recent or current status of medications, existing medical conditions, allergies, recent injuries or illnesses, presence of pain or other physical distress, observations for evidence of illness, injury, physical distress, difficulty moving, etc. and observation for presence of scars, tattoos, or other skin markings.

A review of six (6) residential client files reviewed onsite had evidence of the proper documentation of the CINS/FINS Intake form used to collect information on the current youth's health status. Each health screening form was completed by direct care residential and screening staff. Further review of the 6 health screening documents revealed that the agency is capturing health screening findings and documenting these finding in accordance with the requirements of this indicator. The agency utilizes an additional separate form to document the presence of observation of scars, marks or tattoos. All 6 client files reviewed contained the CINS/FINS intake and the agency's screening forms. The agency has an active medical or injury referral process and follow-up medical care is acted upon on an as needed basis when applicable. The Registered Nurse also reviews the health forms completed by staff to determine and verify accuracy and completeness. Additionally, the RN conducts health screenings on youth when she is on duty.

No exceptions are documented for this indicator.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency has a detailed suicide prevention policy that requires that the agency delineate staff positions, the duties, supervisory roles, involvement of licensed professionals, documentation protocols, notification procedures, and referral systems in connection with suicide prevention and response performed by staff members of this agency. The policy is called Suicide Prevention. The policy has been reviewed and approved by the Regional Director. The reviewer assigned this indicator reports that the policy meets the general requirements of the agency's contract engagement with the Florida Network.

The agency has protocols and a system to screen, assess and identify youth with risk factors for suicide for youth being served in either the residential shelter and or those that are provided services through the agency's non-residential counseling services. Youth that are admitted into the program must have a suicide risk assessment completed, CINS/FINS intake form completed, and a full intake assessment completed by a youth care specialist. The agency must determine if the youth meets the risk indicators listed and the CINS/FINS intake form. If the youth meets one of these risk factors, then the youth must be immediately be placed on elevated supervision. The agency's procedures require the counselor to complete a comprehensive needs assessment and that the assessment score out a rating of low, medium or high. This acts to determine if the youth is at risk of harming self or others. The agency requires the youth be placed on site and sound if the youth is deemed at risk by the clinician. The agency at the time of this onsite review (4) have a total of four licensed clinicians on staff across the 4 county service region. If the clinical assessment determines that the youth can be placed on site and sound supervision, the agency must conduct observation

checks at intervals of 30 minutes or less until the youth is no longer required to be on elevated supervision. The agency's policy mandates that a licensed clinician is the only professional that can determine if the youth can be stepped down from sight and sound supervision. Direct care staff primarily provide sight and sound observations and updates on the status of the child.

A review of the agency suicide prevention was conducted on site. A random sampling of five client keys files that had been placed on elevated supervision was utilized as the sample to verify and confirm the agencies practice. Of these files three or active client case files into work close to client case files.

The review of these files indicates that a suicide risk screening was found in each client case file. The suicide screening results from all five (5) files indicated that the youth had been screened with the agency's intake assessment tool that included the FNYFS intake assessment form. Each client indicated at least one of risk out of the six (6) risk possibilities in all 5 client cases. Each of the client intake forms had evidence that it was completed by a counseling professional and reviewed by a licensed staff person or supervisor as required. Each of the 5 client files had a suicide risk evaluation or EIDS form that was completed and scored out as required. Each client file had documentation that the youth was immediately placed on site and sound supervision until they were assessed by a licensed professional. Each of the suicide risk evaluation forms was completed by a staff person under the direct Supervision of a licensed professional. Each of the 5 cases had evidence that the youth was placed on the appropriate level of supervision based on the suicide risk evaluation. Each of the 5 cases had evidence of that indicated direct care staff began conducting client observation checks at an interval of 30 minutes or less consistently during the time that the youth was on elevated supervision.

All of the suicide risk forms had evidence that they were reviewed by a licensed clinician. All of the 5 files had evidence that the youth was not stepped down until it was approved by a licensed clinician. In two (2) the cases reviewed, the agency had performed multiple suicide risk evaluation forms to continue maintaining the elevated supervision status of each youth. Two (2) of the cases required that the youth stay on elevated supervision the entire time that they were being cared for by the program. At the time of this onsite program review, 2 active cases have both youth currently on elevated supervision status.

A review of the electronic log book revealed that 4 out of the 5 youth were documented as being placed on elevator supervision and stepped down from elevated supervision status as required.

One out of the 5 youth did not have documentation in electronic logbook indicating that they were placed on elevated supervision and 2 separate instances.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on medication distribution. The medication distribution policy is current and includes all required steps to ensure that the agency distribute medication to residents that are in their care. Policy addresses the safe and secure storage, access, Inventory, disposal in a ministratation and distribution of medications in accordance with DJ J health services. The policy was reviewed and approved by the regional director.

The agency has specific procedures in which their staff must follow to ensure the safe and secure delivery of medications to residents in their care during their shelter stay. The agency requires that all medications be stored in a Pyxis MedStation 4000 medication cabinet. The agency does require the cabinet not be accessible to residents. Oral and topical medications cannot be stored together. The agency also has to maintain a minimum of two (2) Super Users that operate the Pyxis MedStation 4000 medication cabinet. The agency requires that the medication that they use to document the distribution of medication to all residents in their care. All controlled medications must be counted and inventoried on a shift to shift basis and verified by a witness and documented. All over the counter medications are required to be inventoried weekly.

The agency's policy requires that one of four methods listed in the FNYFS operations manual be used to verify medication. The agency requires the RN to distribute medications when she's on site. The agency also requires that all discrepancies be cleared on each shift. The agency requires the nurse to produce monthly reports on the distribution of medication and general medication practice.

This reviewer conducted an assessment of the agency's current medication distribution practice with the Registered Nurse. This reviewer found that all medications controlled and uncontrolled and over the counter medications were all stored in the Pyxis MedStation 4000 medication cabinet. The medication cabinet is not accessible and is secured behind a locked door in the RN's office of the youth shelter. The agency at the time of this review had one documented Super User for the Pyxis MedStation. In addition, at the time of this review, the agency does not except youth that are prescribed injectable medications except for you that are prescribed to use epi-pens. All oral & topical medications are stored separately and OTCs inside a locking tray in the Pyxis MedStation cabinet. The registered nurse trains all staff on the agency's medication distribution and provides a certificate of completion. The agency does complete shift to shift counsel are controlled medications.

This was verified by the reviewer. The agency does secure sharps in the bottom drawer of the four drawer cabinet. At the time of this onsite review, the agency had evidence that documented weekly counts of sharps. These weekly sharps counts were documented on individual sharp forms that tracked items including all scissors, nail clippers, and razors. The counts were accurate and complete for all 3 aforementioned items.

All over the counter medications are counted on a weekly basis. The RN produces a monthly inventory and reviews inventory data on a weekly interval for all over the counter meds. The monthly review of medication management results are captured in the Pyxis MedStation portal. The

RN produces Pyxis MedStation reports. The reports produced by the RN include daily discrepancy checks conducted; user summary report; weekly profile override; average number of canceled weekly transactions; controlled substances discrepancy; and other ad hoc reports. When the RN is on duty the nurse primarily distributes and reviews all medication practice from the last time she was on duty.

The agency has documentation for only one Super User. The FNYFS medication policy requires the agency to have a minimum of 2 Super Users. The agency does not clear discrepancies on an ongoing and consistent basis.

The agency has some daily shift to shift counts that don't document controlled substance counts on a consistent basis. See March 11, 12 and 13 Controlled Substance shift inventory on the medication distribution log form for evidence of missed counts.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy called Medical/Mental Health Alert Process. The agency policy includes components that promote and define the agency's emergency medical and dental care. The policy addresses each youth's health condition, physical activity restrictions, allergies, common side effects of prescribed medications, foods and medication contraindication, and other pertinent treatment information is communicated to all staff through a designated alert system. The content in this policy meets the general requirements of this indicator. This policy has been reviewed and signed by the LSF-NW Regional Director.

The agency's alert procedures require all YCS, counselors and supervisors to provide a medical and mental health screening to all eligible residents upon admission to the shelter. Once a youth has an identified risk, the YCS must notify the counselor if there are mental health issues. Additionally, YCS staff must also inform the RN of any clients with medical issues. Staff are also required to document all medical and mental health issues by documenting these on issues on the health screening form, professional log, case progress notes and other forms of program communication. The agency requires that critical client care information be communicated to all staff by utilizing a dry erase board on which general client information is listed. The agency utilizes files to designate the specific type of client that includes CINS/FINS, Families First Network-FFN, Staff Secure, Court-Ordered Clients and Families First Network-FFN clients. The agency also requires that staff use a color-coded dot system that is comprised of an array of color-specific dots to signify Sight and Sound clients; High Risk clients; youth on medication; and clients admitted to the shelter for a Domestic Violence Respite (DVR).

A review of eight (8) open and closed residential and non-residential client files had evidence that the general medical/mental health alert system is active and operating as required. All 8 files were properly screened and had documented use of the agency's color-coded dot identification system. There were no files that had missing alerts.

No deficiencies were noted for this indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has an Episodic/Emergency care policy that has been reviewed and approved by the Regional Director, Beth Decker on 9/5/18. The policy identifies the procedures of ensuring the proper provisions for youth to receive emergency medical and dental care. The policy meets the general requirements of the indicator.

The procedure gives a detailed outline of the necessary steps to take in the case there is an accident/illness that requires off-site care which includes notification of contact of parent/guardian. It is also included in the procedure that the agency should have emergency equipment on site and documentation is made and given to DJJ, CCC or FFN in the case that there is an incident/illness that occurred.

During the reviewer's observation, the agency keeps a folder of episodic drills. 3 episodic drills were reviewed from each shift within the past 6 months. Each drill outlines the scenario taken place, site, date, beginning and ending time for drill, time of contact for appropriate people, time and page for logbook entry, staff involved and critique.

There were 3 real incidents that were reported within the past 6 months that required off-site care. Upon reviewing the incident reports for each, the agency submitted documentation to the CCC. There was documentation made in the logbook on 1 of 3 incidents.

All of the agency staff are trained on emergency/episodic drills are part of staff training requirements.

The reviewer noticed of the 3 episodic drills submitted, all 3 drills were missing time of calls made to appropriate contact and time and page of log entry.

It was also noted that with one of the incidents that required offsite care no medical clearance was given back to the youth upon returning to the shelter, which is needed per policy.