Florida Network of Youth and Family Services
Quality Improvement Program Report

Review of Lutheran Services Florida/NW-Hope House
Residential Program

October 2 - 3, 2019

Compliance Monitoring Services Provided by
CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake                          Satisfactory
2.02 Needs Assessment                             Satisfactory
2.03 Case/Service Plan                            Satisfactory
2.04 Case Management & 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
2.09 Special Populations                          Satisfactory
2.10 Stop Now and Plan (SNAP)                     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 & Special Populations

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

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

Standard 4: Mental Health /Health Services

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

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 100.00%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%
Rating Definitions

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

<table>
<thead>
<tr>
<th>Rating Definition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfactory Compliance</td>
<td>No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.</td>
</tr>
<tr>
<td>Limited Compliance</td>
<td>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.</td>
</tr>
<tr>
<td>Failed Compliance</td>
<td>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.</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>Does not apply.</td>
</tr>
</tbody>
</table>

Reviewer

Members

Ashley Davies, Consultant-Forefront LLC, Florida Network of Youth and Family Services

Tara Frazier, Regional Monitor, Department of Juvenile Justice

Sarah Showers, Shelter Program Manager, Capital City Youth Services

Caitlyn Dorriety, Family Counselor, Anchorage Children’s Home

Jessica Fansler, Contract Management Specialist, Florida Network of Youth & Family Services
Quality Improvement Review
LSF/NW-Hope House – October 2-3, 2019
Lead Reviewer: Ashley Davies

Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care, and (4) Mental Health/Health Services which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2019).

Persons Interviewed

- Chief Executive Officer
- Chief Financial Officer
- Program Coordinator
- Direct – Part time
- Volunteer
- Clinical Director
- Counselor Non-Licensed
- Advocate
- Nurse – Full time
- Executive Director
- Program Director
- Direct – Care Full time
- Intern
- Counselor Licensed
- Case Manager
- Human Resources
- Nurse – Part time
- Chief Operating Officer
- Program Manager
- # Case Managers
- # Program Supervisors
- # Food Service Personnel
- # Healthcare Staff
- # Maintenance Personnel
- # Other (listed by title): ____

Documents Reviewed

- Accreditation Reports
- Affidavit of Good Moral Character
- CCC Reports
- Logbooks
- Continuity of Operation Plan
- Contract Monitoring Reports
- Contract Scope of Services
- Egress Plans
- Fire Inspection Report
- Exposure Control Plan
- Table of Organization
- Fire Prevention Plan
- Grievance Process/Records
- Key Control Log
- Fire Drill Log
- Medical and Mental Health Alerts
- Precautionary Observation Logs
- Program Schedules
- Supplemental Contracts
- Telephone Logs
- Vehicle Inspection Reports
- Visitations Logs
- Youth Handbook
- # Health Records
- # MH/SA Records
- # Personnel/Volunteer Records
- # Training Records
- # Youth Records (Closed)
- # Youth Records (Open)
- # Other: ____

Surveys

- # Youth
- # Direct Care Staff
- # Other: NA

Observations During Review

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

Comments

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


**Strengths and Innovative Approaches**

The shelter’s community food program continues to grow. They are able to provide food and other daily needs for about 500 households each month. They just enrolled in the Good 360 Program with Wal-Mart which is a donation program that they will use for the community.

The shelter had their 11th annual hurricane drill. The HOPE House teams, Red (Preparation), Green (Evacuation), and Blue (Recovery) did an amazing job. The shelter youth also participate in the weeklong chain of events and learned the importance of being ready for a disaster. They focused a lot this year on the sheltering of youth from another CINS/FINS shelter. They had the opportunity last year to host youth and staff from Anchorage in Panama City and learned a lot from that experience.

The shelter has had many different celebrations with the youth including Thanksgiving Day Feast, Christmas and New Year’s celebrations, Super Bowl party, 4th of July fireworks, Halloween/ Harvest party, National Ice Cream Day, and a number of birthday celebrations.

The youth have learned to do comparison shopping, baking, cooking, gardening, organization, and many other things. Comparison shopping covers a range of goods from groceries to clothing to setting up a new apartment.

The youth have visited a fire station and museums. The youth have taken cards and gifts to two nursing homes and visited with the patients there. The youth made and distributed homeless care packages. The youth also sent appreciation cards to members of the military and Golden Star families.

The shelter has had several speakers this year talking to the youth about a variety of subjects including local firefighters, careers such as plumbing, welding, computer tech, auto repair, and weekly Bible study. The youth also toured a fire station.

The youth have learned to make putty, stress balls, crochet, painting, and a variety of craft activities. They have done some yard work, cleaning the vans, creative writing, and made strawberry jam.

The shelter has had two youth with very limited English, and the counseling intern has been that invaluable resource who translates and ensures understanding, not only of the language, but also of the culture.
Standard 1: Management Accountability

Overview

Lutheran Services Florida NW Hope House is managed by a regional director who oversees a quality services manager and a clinical director. At the time of the review there were three vacant youth care specialist (YCS) positions and three vacant YCS temp positions. The Registered Nurse (RN) position was also vacant. The Administrative Assistant position has been restored back to the budget as a full-time position and a YCS was in the process of transitioning back into this position full-time.

The shelter recently had two older vans donated to the program from Okaloosa County. One of the vans has still has the cage inside so this van will be used for maintenance and running errands. The other van will be used to transport youth.

All indicators in standard one were rated satisfactory with exceptions noted in indicators 1.04 Training Requirements and 1.05 Analyzing and Reporting Information. The exceptions noted in 1.04 were in training files reviewed for first year employees that revealed some required trainings completed outside the 120-day requirement. The exceptions noted in 1.05 were due to improvements that are implemented and monitored through the data collection process not being consistently documented in the meeting minutes each month. A deficiency was noted in indicator 1.03 Incident Reporting due to an incident being reported outside the two-hour time frame; however, this deficiency did not result in an exception. All other indicators standard one were rated satisfactory with no deficiencies.

Standard 2: Intervention and Case Management

Overview

Lutheran Services Florida NW Hope House provides residential and non-residential counseling and case management services over four counties, Walton, Escambia, Santa Rosa, and Okaloosa, across Circuit 1.

The clinical director, who is a Licensed Mental Health Counselor (LMHC), oversees both programs. The residential counseling program consists of one master’s level counselor. The non-residential counseling program also consists of one master’s level counselor. The non-residential program also offers Intensive Case Management (ICM) services. ICM services are provided by an ICM coordinator. The ICM coordinator is a master’s level staff.
This location does not offer Stop Now and Plan (SNAP) services. SNAP services for this circuit are provided at a sister shelter operated by the agency in the same circuit. The clinical director oversees ICM services. The program has provided domestic violence, probation respite, and ICM services this review period. At the time of the review the program had not provided any staff secure, domestic minor sex trafficking, or Family and Youth Respite Aftercare (FYRAC) services since the last on-site review. The agency is currently maintaining paper files.

All indicators in standard two were rated satisfactory with the only exception noted in indicator 2.03 Case/Service Plan. The exception in 2.03 was due to none of the residential files reviewed showing completion dates on the Case Plans and three residential files did not have parent signatures on the Case Plan and did not have any documentation of attempts/discussion of Case Plan with the parent to cover the missing parent signature. Indicator 2.10 Stop Now and Plan was rated as “not applicable” as those services are not offered at this location. All other indicators in standard two were rated satisfactory with no deficiencies.

**Standard 3: Shelter Care**

**Overview**

Lutheran Services Florida NW Hope House residential program is lead by a quality services manager and a youth care specialist (YCS) III. The shelter runs three shifts. The YCS III oversees each shift. The first shift has two YCS I staff and two vacant YCS I positions. The second shift has three YCS I staff and one vacant YCS I and YCS II positions. The third shift has a YCS I and YCS II staff and has two vacant YCS I positions.

The camera system was recently upgraded and provides a much clearer resolution. New cabinets and a new sink were installed in the laundry room.

The youth shelter is a residential home that has been converted into a shelter. There are three bedrooms upstairs, one-bedroom sleeps four youth and the other two bedrooms sleep two youth each. The one bedroom that sleeps four youth is primarily used for the boys’ room and the other two bedrooms are primarily used for the girls.

There are eight beds licensed for CINS/FINS services. At the time of the review there were five CINS/FINS youth in the shelter.

All indicators in standard three were rated satisfactory with exceptions noted in indicators 3.01 Shelter Environment and 3.04 Logbooks. Exceptions noted in 3.01 were due to chemicals being inventoried on a monthly basis instead of weekly. Exceptions noted in 3.04 were due to the program director not documenting weekly reviews of the...
logbook. All other indicators in standard three were rated satisfactory with no deficiencies.

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

**Overview**

The residential counseling services in the shelter are overseen by the clinical director who is a Licensed Mental Health Counselor (LMHC). Services are provided by one master’s level counselor.

All youth are screened for suicide at intake using the six approved questions on the CINS Intake Assessment form and the Suicide Risk Evaluation (SRE). If youth receive a positive screening they are placed on sight and sound supervision until seen and assessed by a qualified mental health professional. All staff receive training on suicide prevention.

Health services are overseen by a part-time registered nurse (RN). At the time of the review the RN position was vacant. The previous RN resigned August 31, 2019. A new RN was hired but resigned during the first twenty-one hours of training. The agency has the position advertised again and the shelter was in the process of trying to hire another RN for the position.

At the time of the review trained YCS were distributing medications and the YCS III was overseeing the process. All newly hired staff are trained on the medication distribution process and the Pyxis Med-Station 4000 Medication Cabinet. Refresher training is provided for as needed. All medications in the facility are stored in the Pyxis Med-Station 4000 Medication Cabinet. YCS complete shift-to-shift inventories of all controlled medications and maintain perpetual inventories of all other medications.

All indicators in standard four were rated satisfactory with the only exception noted in indicator 4.03 Medication. The exception noted in 4.03 was due to the shelter not currently having a RN. All other indicators in standard four were rated satisfactory with no deficiencies.
### STANDARD 1: MANAGEMENT ACCOUNTABILITY

<table>
<thead>
<tr>
<th>Quality Improvement Indicators</th>
<th>Rating</th>
<th>Review Based Upon</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Satisfactory</td>
<td>Document Source: Interview/Surveys, Observation, and/or Type of Documentation</td>
<td>Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)</td>
</tr>
<tr>
<td></td>
<td>Deficiency Identified</td>
<td>Summarize Findings Based on Completed Worksheets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No Eligible Items For Review</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not Applicable</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Standard One – Management Accountability

**1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers**

Provider has a written policy and procedure that meets the requirement for Indicator 1.01

<table>
<thead>
<tr>
<th>RATING</th>
<th><strong>YES</strong></th>
<th><strong>NO</strong> (explain)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>No exceptions</td>
</tr>
</tbody>
</table>

There were two newly hired staff who were reviewed for a background screening completed prior to hire. Both documented a background screening was completed prior to hire with an eligible rating. Both staff were applicable for a pre-employment suitability assessment and both had one completed using the Predictive Index. Both staff had documentation of E-Verify obtained from the Department of Homeland Security. There was one staff eligible for a 5-year rescreening and the rescreening was completed as required. The Affidavit of Annual Compliance was completed and submitted on January 10, 2019.

**1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care**

Provider has a written policy and procedure that meets the requirement for Indicator 1.02

<table>
<thead>
<tr>
<th>RATING</th>
<th><strong>YES</strong></th>
<th><strong>NO</strong> (explain)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>No exceptions</td>
</tr>
</tbody>
</table>

A policy is in place titled Provision of an Abuse Free Environment and was
# Quality Improvement Review

**LSF/NW-Hope House – October 2-3, 2019**  
**Lead Reviewer: Ashley Davies**

<table>
<thead>
<tr>
<th>Quality Improvement Indicators</th>
<th>Rating</th>
<th>Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Satisfactory</td>
<td>Interview/Surveys, Observation, and/or Type of Documentation</td>
<td>Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)</td>
</tr>
<tr>
<td></td>
<td>Deficiency Identified</td>
<td>Summarize Findings Based on Completed Worksheets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No Eligible Items For Review</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not Applicable</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**RATING**

- All staff have signed a code of conduct. There is signage throughout the facility reflecting all youth are accepted. There are postings of the Abuse Hotline number in the shelter. The program has a process in place for documenting abuse hotline calls. Management takes immediate action to address incidents of physical, psychological abuse, verbal intimidation, use of profanity, or excessive use of force. There is an accessible grievance process in place. There is a locked grievance box in the shelter. Direct care staff do not handle grievances. Youth have access to blank grievance forms. There has been one grievance in the last six months filed 9/28/19. Staff was in the process of addressing that grievance at the time of the review.

**1.03: Incident Reporting**

Provider has a written policy and procedure that meets the requirement for Indicator 1.03

- **YES**
- **NO** (explain)

There is a policy in place titled Incident Reporting that was last reviewed October 3, 2019 by the Regional Director.

**RATING**

- The program notified the Department’s CCC no later than two hours after reportable incidents in nine out of ten incidents in the last six months. One incident was reported outside the two-hour time frame. Any follow up tasks required.

Deficiencies noted did not result in any exceptions.
### Quality Improvement Review

**LSF/NW-Hope House – October 2-3, 2019**

Lead Reviewer: Ashley Davies

### Quality Improvement Indicators

<table>
<thead>
<tr>
<th>Rating</th>
<th>Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfactory</td>
<td>Deficiency Identified</td>
</tr>
</tbody>
</table>

#### Review Based Upon Document Source:
- Interview/Surveys,
- Observation, and/or Type of Documentation

Summarize Findings Based on Completed Worksheets

#### Notes
- Explain Exception, Failed, or Not Applicable Indicators:
  (Attach Supportive Documentation)

---

**1.04: Training Requirements**

**Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions**

- **Provider has a written policy and procedure that meets the requirement for Indicator 1.04**
  - YES
  - NO (explain)

- **RATING**
  - ☐
  - ☒
  - ☐
  - ☐
  - ☐

A policy in place titled Training Requirements that was reviewed October 3, 2019 by the Regional Director.

No exceptions

An individual training file was maintained for each staff that includes an annual employee training hour tracking form and related documentation. There were two staff training files reviewed for training completed in the first year of employment. One staff had well over the required 80 hours of training for the first year with three months left to receive additional trainings. There were two trainings completed after the 120-day requirement. Suicide Prevention and Child Abuse. Both trainings were completed in Skill Pro; however, were completed outside the 120-day requirement. This staff still had time to receive all additional trainings required after the first 120 days. The second staff has documented 81.25 training hours for the first year of employment. There were two staff training files reviewed for training completed in the first year of employment. One staff had two trainings that were completed after the 120-day requirement. The other staff also had the same two trainings completed after the 120-day requirement, as well as, three additional trainings required during the first year that were not completed.
### Quality Improvement Review

**LSF/NW-Hope House – October 2-3, 2019**

**Lead Reviewer: Ashley Davies**

<table>
<thead>
<tr>
<th>Quality Improvement Indicators</th>
<th>Rating</th>
<th>Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Satisfactory</td>
<td>Deficiency Identified</td>
<td>No Eligible Items For Review</td>
</tr>
</tbody>
</table>

**Explain**

- **Review Based Upon Document Source:**
  - Interview/Surveys,
  - Observation, and/or Type of Documentation

- **Summarize Findings Based on Completed Worksheets**

**RATING**

- The program collects and reviews several sources of information to identify patterns and trends. Program should have sample reports of aggregated data and committee/workgroup minutes analyzing information.

**Provider has a written policy and procedure that meets the requirement for Indicator 1.05**

- **YES**
  - There is a policy in place titled Analyzing and Reporting Information that was last reviewed October 3, 2019 by the Regional Director.

**Notes**

- **Explain Exception, Failed, or Not Applicable Indicators:**
  - (Attach Supportive Documentation)

**Two trainings completed after the 120-day requirement, Suicide Prevention and Child Abuse. Both trainings were completed in Skill Pro; however, were completed outside the 120-day requirement. There was also one other training, CINS/FINS Core, required in the first 120 days that was not documented as being completed. This staff also had three additional trainings that were required in the first year that were not completed. There were five staff training files reviewed for annual training requirements. The 2019 training cycle was reviewed so all five staff still had three months left in the cycle to receive additional trainings. All five staff were on track to receive all required trainings and had already received more than the required 40 hours.**

**RATING**

- The agency has six different committees to review and report on all required data monthly. The six committees are: Safety, Risk Management, Consumer Satisfaction, Program Improvement, Improvements that are implemented and monitored through the data collection process were not consistently documented in the meeting minutes each month.
### Quality Improvement Review

**LSF/NW-Hope House – October 2-3, 2019**  
**Lead Reviewer: Ashley Davies**

<table>
<thead>
<tr>
<th>Quality Improvement Indicators</th>
<th>Rating</th>
<th>Explain</th>
<th>Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Summarize Findings Based on Completed Worksheets</td>
<td>Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)</td>
</tr>
<tr>
<td></td>
<td>Satisfactory</td>
<td>Deficiency Identified</td>
<td>No Eligible Items For Review</td>
<td>No Practice</td>
</tr>
<tr>
<td>Candidate Indicators</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Outcome Measurements, and Case Review.** The agency completes monthly reviews of case records. There are also monthly reviews of incidents, accidents, and grievances, if applicable. Customer satisfaction data is reviewed monthly. NetMIS data is reviewed monthly. Findings from these monthly reviews are discussed during the monthly team meetings that include all program staff. Strengths and weaknesses are identified; however, improvements that are implemented and monitored through these meetings were not consistently documented in the meeting minutes each month. The agency has identified a process to review and improve accuracy of data entry and collection. The Clinical Director will review information in JJIS monthly to ensure accuracy of data entry and collection. At the time of the review this process had not started; however, was described in the policy.

**1.06: Client Transportation**

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.

Provider has a written policy and procedure that meets the requirement for Indicator 1.06

- ☑ YES
- ☐ NO (explain)

A policy titled Client Transportation is in place and was reviewed on October 3, 2019 by the Regional Director.

No exceptions

**RATING**

- ☑
- ☐
- ☐
- ☐
- ☐

Staff approved for transporting youth have valid Florida Driver’s License and are covered under the agency’s auto insurance.

No exceptions
## Quality Improvement Review

**LSF/NW-Hope House – October 2-3, 2019**  
Lead Reviewer: Ashley Davies

### Rating

<table>
<thead>
<tr>
<th>Quality Improvement Indicators</th>
<th>Rating</th>
<th>Explain</th>
<th>Review Based Upon</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Satisfactory</td>
<td>Deficiency Identified</td>
<td>Document Source: Interview/Surveys, Observation, and/or Type of Documentation</td>
<td>Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)</td>
</tr>
<tr>
<td></td>
<td>No Eligible Items For Review</td>
<td>No Practice</td>
<td>Summarize Findings Based on Completed Worksheets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not Applicable</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 1.07: Outreach Services

The agency participates in local DJJ board and council meetings to increase public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services and ensure CINS/FINS services are represented in a coordinated approach.

**Provider has a written policy and procedure that meets the requirement for Indicator 1.07**

<table>
<thead>
<tr>
<th>RATING</th>
<th>YES</th>
<th>NO (explain)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☒</td>
<td></td>
<td>No exceptions</td>
</tr>
</tbody>
</table>

A policy titled Outreach Services is in place and was reviewed on October 3, 2019 by the Regional Director.

Local DJJ Board and Council Meetings are attended and minutes are collected. Documentation in Netmis was provided for the time period of March 1, 2019 – October 2, 2019 showing that outreach has been taking place throughout the community through various events, meetings, and activities. The agency has a multi-dimensional food assistance program for the families in the community which also provides the opportunity to educate the community about the services the agency can provide. The agency has

---

*Copyright (c) Forefront Revised Aug 2019*
<table>
<thead>
<tr>
<th>Quality Improvement Indicators</th>
<th>Rating</th>
<th>Explain</th>
<th>Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfactory</td>
<td></td>
<td></td>
<td>Summarize Findings Based on Completed Worksheets</td>
<td></td>
</tr>
<tr>
<td>Deficiency Identified</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Eligible Items For Review</td>
<td></td>
<td></td>
<td>Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)</td>
<td></td>
</tr>
<tr>
<td>No Practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Applicable</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

food distribution records that track the number of families they make contact with and provide assistance too. The agency provided six current Memorandums of Understanding (MOU).
# Standard Two – Intervention and Case Management

## 2.01: Screening and Intake

Provider has a written policy and procedure that meets the requirement for Indicator 2.01  

<table>
<thead>
<tr>
<th>Rating</th>
<th>Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Interview/Surveys, Observation, and/or Type of Documentation</td>
<td></td>
</tr>
</tbody>
</table>

**RATING**

- Yes
- No

There were five residential (three closed and two open) and five non-residential (three open and two closed) files reviewed. All ten of the files were screened for eligibility within seven days of the referral. All ten files also showed that the youth and guardian had been made aware of their rights and responsibilities, available service options, possible actions occurring through involvement with CINS/FINS, and grievance procedures.

**RATING**

- Yes
- No

There is a policy in place titled Screening and Intake that was last reviewed on October 3, 2019 by the regional director. No exceptions.

## 2.02: Needs Assessment

Provider has a written policy and procedure that meets the requirement for Indicator 2.02  

<table>
<thead>
<tr>
<th>Rating</th>
<th>Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Interview/Surveys, Observation, and/or Type of Documentation</td>
<td></td>
</tr>
</tbody>
</table>

**RATING**

- Yes
- No

There were five residential (three closed and two open) and five non-residential (three open and two closed) files reviewed. All ten of the files were screened for eligibility within seven days of the referral. All ten files also showed that the youth and guardian had been made aware of their rights and responsibilities, available service options, possible actions occurring through involvement with CINS/FINS, and grievance procedures.

**RATING**

- Yes
- No

There is a policy in place titled Needs Assessment that was last reviewed on October 3, 2019 by the regional director. No exceptions.
**Quality Improvement Review**

**LSF/NW-Hope House – October 2-3, 2019**

**Lead Reviewer: Ashley Davies**

<table>
<thead>
<tr>
<th>Quality Improvement Indicators</th>
<th>Rating</th>
<th>Explain</th>
<th>Review Based Upon</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Satisfactory</td>
<td>Deficiency Identified</td>
<td>Document Source: Interview/Surveys, Observation, and/or Type of Documentation</td>
<td>Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)</td>
</tr>
<tr>
<td></td>
<td>No Eligible Items For Review</td>
<td>No Practice</td>
<td>Summarize Findings Based on Completed Worksheets</td>
<td></td>
</tr>
</tbody>
</table>

**2.03 Case/Service Plan**

**Provider has a written policy and procedure that meets the requirement for Indicator 2.03**

- ☑ YES
- ☐ NO (explain)

- There is a policy in place titled Case/Service Plan that was last reviewed on October 3, 2019 by the regional director.

- No exceptions

**RATING**

- ☑
- ☒
- ☐
- ☐
- ☐

- There were five residential (three closed and two open) and five non-residential (three open and two closed) files reviewed. All ten files reviewed had Case Plans completed within seven days of the Needs Assessment. All ten assessments were conducted by at least a master’s level counselor and all had signatures from the supervisor once completed. None of the reviewed files had an elevated risk of suicide.

- Of the five residential files reviewed none of the files showed completion dates on the Case Plans. Three residential files did not have parent signatures on the Case Plan and did not have any documentation of attempts/discussion of Case Plan with the parent to cover the missing parent signature.
## Quality Improvement Review

**LSF/NW-Hope House – October 2-3, 2019**  
**Lead Reviewer: Ashley Davies**

### Quality Improvement Indicators

<table>
<thead>
<tr>
<th>Rating</th>
<th>Explain</th>
<th>Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfactory</td>
<td></td>
<td>Summarize Findings Based on Completed Worksheets</td>
<td></td>
</tr>
<tr>
<td>Deficiency Identified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Eligible Items For Review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Applicable</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Rating

- **Satisfactory**
- **Deficiency Identified**
- **No Eligible Items For Review**
- **No Practice**
- **Not Applicable**

#### Explain

signature clearly documented and dated. All five residential files and three of the non-residential files had the supervisor signature located on the Case Plan. Two of the non-residential files had missing supervisor signatures on the Case Plan but thorough case notes showed that the files and the Case Plans had been reviewed by the supervisor. Four residential files did not have parent signatures on the Case Plan. Of the four files with missing parent signatures, three of the files also did not have documentation of attempts/discussion of Case Plan with the parent to cover the missing parent signature. One non-residential case did not have a parent signature on the case plan but did have sufficient documentation of attempts. None of the residential files were eligible for case review either because the case was closed before the thirty-day mark or the file is not yet due for a case review. Of the eligible non-residential files all have thirty-day Case Plan reviews and updates.

#### 2.04: Case Management and Service Delivery

**Provider has a written policy and procedure that meets the requirement for Indicator 2.04**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO (explain)</th>
<th>No exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**There is a policy in place titled Case Management and Service Delivery that was last reviewed on October 3, 2019 by the regional director.**
## Quality Improvement Review

**LSF/NW-Hope House – October 2-3, 2019**  
Lead Reviewer: Ashley Davies

<table>
<thead>
<tr>
<th>Quality Improvement Indicators</th>
<th>Rating</th>
<th>Explain</th>
<th>Review Based Upon</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Satisfactory</td>
<td>Deficiency Identified</td>
<td>Document Source: Interview/Surveys, Observation, and/or Type of Documentation</td>
<td>Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)</td>
</tr>
<tr>
<td></td>
<td>No Eligible Items For Review</td>
<td>No Practice</td>
<td>Summarize Findings Based on Completed Worksheets</td>
<td></td>
</tr>
<tr>
<td>RATING</td>
<td>☒</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

### 2.05: Counseling Services

**Provider has a written policy and procedure that meets the requirement for Indicator 2.05**

- ☒ YES  
- ☐ NO (explain)  

There is a policy in place titled Counseling Services that was last reviewed on October 3, 2019 by the regional director.

No exceptions

---

There were five residential (three closed and two open) and five non-residential (three open and two closed) files reviewed. All ten files reviewed had an assigned counselor who provided satisfactory case management and service delivery. None of the ten files reviewed showed a need for a referral but did show that there is a documentation process for referrals. For each reviewed file the Case Plans were implemented, and counselors/case managers monitored case progress and provided support to the families. Out-of-home placements and case staffing’s were not applicable for the five residential files and four non-residential files reviewed but was applicable and satisfactory for one non-residential file. None of the reviewed files had a need for a counselor/case manager to monitor or accompany any youth to court hearings but a policy is in place. All ten files demonstrated successful thirty- and sixty-day follow-ups and termination documentation. No exceptions
# Quality Improvement Review

**LSF/NW-Hope House** – October 2-3, 2019  
Lead Reviewer: Ashley Davies

<table>
<thead>
<tr>
<th>Quality Improvement Indicators</th>
<th>Rating</th>
<th>Explain</th>
<th>Review Based Upon</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Satisfactory</td>
<td>Deficiency Identified</td>
<td>No Eligible Items For Review</td>
<td>No Practice</td>
</tr>
<tr>
<td>RATING</td>
<td>✖</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>

### 2.06: Adjudication/Petition Process

Provider has a written policy and procedure that meets the requirement for Indicator 2.06

<table>
<thead>
<tr>
<th>RATING</th>
<th></th>
<th>No Practice</th>
<th></th>
<th>Not Applicable</th>
</tr>
</thead>
</table>

|  | ✖ | ✔ | ✔ | ✔ | ✔ | There is a policy in place titled Adjudication/Petition Process that was last reviewed on October 3, 2019 by the regional director. | No exceptions |

### 2.07: Youth Records

<table>
<thead>
<tr>
<th>Rating</th>
<th>Explain</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>✖</td>
<td>✔</td>
<td>Though a policy is in place there have been no adjudication/petition cases in over six months.</td>
</tr>
</tbody>
</table>

---

*Copyright (c) Forefront Revised Aug 2019*
### Quality Improvement Indicators

<table>
<thead>
<tr>
<th>Quality Improvement Indicators</th>
<th>Rating</th>
<th>Explain</th>
<th>Review Based Upon</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Document Source:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Interview/Surveys,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Observation, and/or</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Type of</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Documentation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Summarize Findings Based on Completed Worksheets</td>
<td></td>
</tr>
</tbody>
</table>

#### 2.07: Provider has a written policy and procedure that meets the requirement for Indicator 2.07

<table>
<thead>
<tr>
<th>RATING</th>
<th>Satisfactory</th>
<th>Deficiency Identified</th>
<th>No Eligible Items For Review</th>
<th>No Practice</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑️</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **YES**
- **No (explain)**

- There is a policy in place titled Youth Records that was last reviewed on October 3, 2019 by the regional director. No exceptions.

#### 2.08: Provider has a written policy and procedure that meets the requirement for Indicator 2.08

<table>
<thead>
<tr>
<th>RATING</th>
<th>Satisfactory</th>
<th>Deficiency Identified</th>
<th>No Eligible Items For Review</th>
<th>No Practice</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑️</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **YES**
- **No (explain)**

- There is a policy in place titled Sexual Orientation, Gender Identity, and Gender Expression that was last reviewed October 3, 2019 by the regional director. No exceptions.

#### 2.08: Sexual Orientation, Gender Identity, Gender Expression

- All staff are trained on all policy and procedures during orientation training, which includes a review of this policy. Youth participating in services with this shelter have all identified as cisgender, they have not had any situations working with gender expansive youth in the last year. There are two signs in the shelter indicating it is a “safe place” or “safe zone” for LGBTQ+ youth. No exceptions.
### Quality Improvement Indicators

<table>
<thead>
<tr>
<th>Quality Improvement Indicators</th>
<th>Rating</th>
<th>Review Based Upon</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Document Source:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Interview/Surveys,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Observation, and/or</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Type of Documentation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Summarize Findings Based on Completed Worksheets</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Explain Exception, Failed, or Not Applicable Indicators:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Attach Supportive Documentation)</td>
<td></td>
</tr>
</tbody>
</table>

#### 2.09: Special Populations

**Provider has a written policy and procedure that meets the requirement for Indicator 2.09**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑</td>
<td>YES</td>
</tr>
</tbody>
</table>

There is a policy in place titled Special Populations that was last reviewed October 3, 2019 by the Regional Director.

**RATING**

- ☑
- ☐
- ☐
- ☐
- ☐
- ☐

The agency did not have any examples of Staff Secure, Domestic Minor Sex Trafficking, FYRAC, or Probation Respite to review for the past year. There were three domestic violence (DV) files reviewed. All three had a pending DV charge. Data entry was entered into NetMIS in the time frames. None of the youth stayed longer than twenty-one days. Case plans focused on anger management and family coping skills. All other services provided were consistent with all other general CINS/FINS program requirements. There were four Intensive Case Management files reviewed. All four youth were court ordered to the program. All four files documented well over the six required direct and collateral contacts each month. All four files documented a Child Behavior Checklist was completed within fourteen days of intake. All had evidence of a youth self-report assessment completed at intake and at least every 90 days. All case plans demonstrated a strength-based, trauma-informed focus. All four files contained a plethora of documentation of engaging the youth.
## Quality Improvement Indicators

<table>
<thead>
<tr>
<th>Rating</th>
<th>Explain</th>
<th>Review Based Upon</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfactory</td>
<td></td>
<td>Document Source: Interview/Surveys, Observation, and/or Type of Documentation</td>
<td>Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)</td>
</tr>
<tr>
<td>Deficiency Identified</td>
<td></td>
<td>Summarize Findings Based on Completed Worksheets</td>
<td></td>
</tr>
<tr>
<td>No Eligible Items For Review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Applicable</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 2.10: STOP NOW AND PLAN (SNAP)

Provider has a written policy and procedure that meets the requirement for Indicator 2.10

<table>
<thead>
<tr>
<th>RATING</th>
<th>YES</th>
<th>NO (explain)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This indicator was rated as not applicable as the provider does not offer SNAP services at this location. All SNAP services are provided at a sister shelter operated by the agency in the same circuit.
## STANDARD 3: SHELTER CARE

<table>
<thead>
<tr>
<th>Quality Improvement Indicators</th>
<th>Rating</th>
<th>Explain</th>
<th>Review Based Upon</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Document Source: Interview/Surveys, Observation, and/or Type of Documentation</td>
<td>Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)</td>
</tr>
<tr>
<td></td>
<td>Satisfactory</td>
<td>Deficiency Identified</td>
<td>No Eligible Items For Review</td>
<td>No Practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Standard Three – Shelter Care

#### 3.01 Shelter Environment
The shelter’s environment is safe, clean, neat and well maintained. The program provides structured daily programming to engage youth in activities that foster health, social, emotional, intellectual and physical development.

Provider has a written policy and procedure that meets the requirement for Indicator 3.01

- **YES**
  - A policy is in place titled Shelter Environment that was last reviewed on October 3, 2019 by the regional director.

No exceptions

**RATING**

- The program is well maintained, free of debris, hazards, and contraband both inside and outside, as well as free of insect infestation. All doors were secure, including personal and program vehicles on the premises. The only graffiti observed was on the closet door in bedroom number one. The only garbage can in the program is in the kitchen, but the cover was propped up next to the can, not on the can. The dumpsters outside were covered. The program has two vehicles, and both were equipped with the major safety equipment. In and out access is limited to staff members with key control compliance. All appropriate forms are posted inside the program. The agency has a current DCF Child Care License valid through September 2020. Each youth has their own individual bed with

- Inventory on chemicals has a monthly perpetual count, but is not inventoried weekly, as per policy and procedure.

Copyright (c) Forefront Revised Aug 2019
## Quality Improvement Review

### Lead Reviewer: Ashley Davies

**LSF/NW-Hope House – October 2-3, 2019**

<table>
<thead>
<tr>
<th>Quality Improvement Indicators</th>
<th>Rating</th>
<th>Review Based Upon</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Document Source:</td>
<td>Explain Exception, Failed, or Not Applicable Indicators:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Interview/Surveys,</td>
<td>(Attach Supportive Documentation)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Observation, and/or Type of Documentation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Summarize Findings Based on Completed Worksheets</td>
<td></td>
</tr>
<tr>
<td>Clean and sufficient linens, blanket, and pillows. An operational washer and dryer are available at the program. Most of the youth’s property is sent home with the parents, however, there is a locked safe on property for youth’s personal belongings. The program had their annual fire inspection conducted with the local fire marshal this year. The agency has a current satisfactory food service and satisfactory residential group care inspection report from the Department of Health this year. The program’s fire extinguisher and alarm system were inspected this year and are up to date. The program conducted mandatory fire drills monthly and at least one mock drill per shift quarterly. All food is stored appropriately. The Maytag refrigerator was running at 52 degrees Fahrenheit, which is above average temperature. All chemicals on-site have a monthly perpetual count, but are not inventoried weekly, as per policy and procedure. Each chemical had a MSDS maintained for that item in a binder in the Youth Care Specialist’s office. The program encourages youth to engage in meaningful, structured activities, including one hour of physical activity daily, homework, and reading. The daily schedule is posted in the program and in the youth’s handbook. Youth may...</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Quality Improvement Indicators

<table>
<thead>
<tr>
<th>Rating</th>
<th>Review Based Upon</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Document Source: Interview/Surveys, Observation, and/or Type of Documentation</td>
<td>Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)</td>
</tr>
<tr>
<td></td>
<td>Summarize Findings Based on Completed Worksheets</td>
<td></td>
</tr>
</tbody>
</table>

### Quality Improvement Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Rating</th>
<th>Explain</th>
<th>Review Based Upon</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.02: Program Orientation</td>
<td>☑ YES</td>
<td>A policy is in place titled Program Orientation that was last reviewed on October 3, 2019 by the regional director.</td>
<td>No exceptions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☑ NO (explain)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.03: Youth Room Assignment</td>
<td>☑ YES</td>
<td>A policy is in place titled Youth Room Assignment that was last reviewed on October 3, 2019 by the regional director.</td>
<td>No exceptions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☑ NO (explain)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 3.02: Program Orientation

Provider has a written policy and procedure that meets the requirement for Indicator 3.02

RATING

| ☑ | ☑ | ☑ | ☑ | ☑ |

There were five youth files reviewed. All five youth received a comprehensive orientation on the date of admission. At orientation, the youth receives a handbook which includes the following, disciplinary action, the grievance procedure, emergency procedures, contraband rules, a tour of the program, room assignment, signature of youth and parent, daily activities, and the number of the abuse hotline. None of the five youth were admitted with a suicide hit and needed to be placed on the suicide prevention alert notification.

No exceptions

### 3.03: Youth Room Assignment

Provider has a written policy and procedure that meets the requirement for Indicator 3.03

RATING

| ☑ | ☑ | ☑ | ☑ | ☑ |

There were five youth files reviewed. All five youth were assigned a room based upon an initial classification. This

No exceptions
## Quality Improvement Review

**LSF/NW-Hope House – October 2-3, 2019**

**Lead Reviewer: Ashley Davies**

<table>
<thead>
<tr>
<th>Quality Improvement Indicators</th>
<th>Rating</th>
<th>Explain</th>
<th>Review Based Upon</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Satisfactory</td>
<td>Deficiency Identified</td>
<td>Document Source: Interview/Surveys, Observation, and/or Type of Documentation</td>
<td>Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)</td>
</tr>
</tbody>
</table>

### 3.04: Log Books

**Provider has a written policy and procedure that meets the requirement for Indicator 3.04**

<table>
<thead>
<tr>
<th>RATING</th>
<th>☑ YES</th>
<th>☐ NO (explain)</th>
<th>☐ No exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☑</td>
<td>☐</td>
<td>The program director has not conducted any weekly reviews of the logbook.</td>
</tr>
</tbody>
</table>

The program uses NoteActive, an electronic logbook. All entries were brief and legible, and included the date and time of the incident/activity/event, names of youth/staff, brief statement, and signature of the staff making the entry. Any safety and security issues which could impact the youth and/or program were highlighted. All direct care and supervisory staff review the logbook at the beginning of each shift for the previous two shifts. Documentation of this review is in the logbook with the date and the signature of the staff at the time of the entry. All supervision and resident counts, as well as visitation, or home visits are documented in the logbook.
## Quality Improvement Review

**LSF/NW-Hope House – October 2-3, 2019**  
Lead Reviewer: Ashley Davies

### Quality Improvement Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Rating</th>
<th>Explain</th>
<th>Review Based Upon</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.05: Behavior Management Strategies</td>
<td></td>
<td></td>
<td>Document Source: Interview/Surveys, Observation, and/or Type of Documentation</td>
<td></td>
</tr>
</tbody>
</table>

**Provider has a written policy and procedure that meets the requirement for Indicator 3.05**

- YES  
- NO (explain)

**A policy is in place titled Behavior Management Strategies that was last reviewed on October 3, 2019 by the regional director.**

**RATING**

- Yes

**The program has a detailed written description of the behavior management motivation system (BMMS) in the youth's handbook, which is explained during orientation. The program uses appropriate interventions to teach youth new behaviors and help them understand natural consequences for their actions, as well as a wide variety of positive incentives and rewards to encourage participation to complete the program. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior. Consequences for a violation of program rules are applied logically and consistently. BMMS provides constructive discipline that encourages youth to meet behavior expectations. It provides for positive reinforcement and recognition, minimizing separation of youth from the general population. Disciplinary measures never deny the youth their basic rights. Overall, BMMS promotes order, safety, security, respect, fairness, and protection of resident rights. All staff are trained in the theory and**

No exceptions
### Quality Improvement Review

**LSF/NW-Hope House – October 2-3, 2019**

**Lead Reviewer: Ashley Davies**

<table>
<thead>
<tr>
<th>Quality Improvement Indicators</th>
<th>Rating</th>
<th>Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Satisfactory</td>
<td>Deficiency Identified</td>
</tr>
</tbody>
</table>

#### Rating

**Review Based Upon Document Source:** Interview/Surveys, Observation, and/or Type of Documentation

**Summarize Findings Based on Completed Worksheets**

**Notes**

**RATING**

<table>
<thead>
<tr>
<th>3.06: Staffing and Youth Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider has a written policy and procedure that meets the requirement for indicator 3.06</td>
</tr>
<tr>
<td>☑ YES  ☐ NO (explain)</td>
</tr>
</tbody>
</table>

**RATING**

| ☑  ☐  ☐  ☐  ☐  ☐ | The agency maintains a minimum staffing ratio of one staff to six youth during awake hours and community activities. The staff ratio is one staff to twelve youth during sleeping periods. There were a minimum of two staff present during overnight shifts. This was observed via staff schedules, the electronic logbook documentation, and while reviewing the video surveillance system. The staff schedule is maintained in the “Pass Down” folder located in the YCS Office, where staff can easily access the schedule. There is a roster, listing staff and their contact information in case additional staff coverage is necessary. This information is also located in the |

**No exceptions**
### 3.07: Video Surveillance System

Provider has a written policy and procedure that meets the requirement for Indicator 3.07

<table>
<thead>
<tr>
<th>Rating</th>
<th>Explanations</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑</td>
<td>YES</td>
</tr>
<tr>
<td>☐</td>
<td>NO</td>
</tr>
</tbody>
</table>

A policy titled Video Surveillance is in place and was reviewed on October 3, 2019 by the Regional Director.

The surveillance system was updated since the last review (approximately three weeks ago). There are interior and exterior cameras taking surveillance footage twenty-four hours a day seven days a week. All cameras are visible. There are no cameras located in any of the bathrooms or bedrooms. The surveillance system retains footage for thirty days and has a backup battery system to ensure that the surveillance system continues to operate when there is a power outage. The surveillance system records date, time and location, while maintaining a resolution that allows for facial recognition. There is a list of the personnel that have access to the surveillance footage. They are able to access the surveillance system remotely. The surveillance camera logbook was reviewed and indicated that the supervisor...
## Quality Improvement Review

<table>
<thead>
<tr>
<th>Quality Improvement Indicators</th>
<th>Rating</th>
<th>Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Satisfactory</td>
<td>Deficiency Identified</td>
</tr>
</tbody>
</table>

### Review Based Upon
- Document Source: Interview/Surveys, Observation, and/or Type of Documentation
- Summarize Findings Based on Completed Worksheets

### Notes
- Explain Exception, Failed, or Not Applicable Indicators:
  - (Attach Supportive Documentation)

---

is conducting fourteen-day reviews of the surveillance system. There is a process for a third party to receive video recordings if/when requested.
### Standard Four – Mental Health / Health Services

#### 4.01: Healthcare Admission Screening

<table>
<thead>
<tr>
<th>Quality Improvement Indicators</th>
<th>Rating Explain</th>
<th>Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfactory</td>
<td></td>
<td>Summarize Findings Based on Completed Worksheets</td>
<td>Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)</td>
</tr>
<tr>
<td>Deficiency Identified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Eligible Items For Review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Applicable</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Provider has a written policy and procedure that meets the requirement for Indicator 4.01

- **YES**
  - The agency has a policy in place titled Healthcare Screening Admission that was last reviewed October 3, 2019 by the regional director.
- **NO** (explain)

#### Rating

| RATING | | | | | |
|--------|---|---|---|---|
| ☒ | ☐ | ☐ | ☐ | ☐ | |

- At intake into the facility the staff assess medical needs by completing the CINS/FINS Intake Assessment form which includes a physical health screening and a visual inspection of the youth. The shelter nurse reviews all intakes within five business days. If there is a medical, dental, or mental health condition that exists, the youth care staff will contact the counselor. The counselor will contact the parent/guardian. There were five youth files reviewed, three opened and two closed. All five files documented the CINS/FINS Intake form was completed on the day of admission. There was one youth on medication for allergies and one youth with a recent injury. These conditions were documented in the file and also entered into the shelters alert system. The shelter has procedures in place for follow-up care if it is needed. None of the
## Quality Improvement Review

**LSF/NW-Hope House – October 2-3, 2019**  
Lead Reviewer: Ashley Davies

---

<table>
<thead>
<tr>
<th>Quality Improvement Indicators</th>
<th>Rating</th>
<th>Explain</th>
<th>Review Based Upon</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Satisfactory</td>
<td>Deficiency Identified</td>
<td>No Eligible Items For Review</td>
<td>No Practice</td>
</tr>
</tbody>
</table>

### 4.02 Suicide Prevention

There is a written plan that details the program’s suicide prevention and response procedures. The plan complies with the procedures outlined in the Florida Network’s Policy and Procedure Manual for CINS/FINS.

Provider has a written policy and procedure that meets the requirement for Indicator 4.02

<table>
<thead>
<tr>
<th>RATING</th>
<th>YES</th>
<th>NO (explain)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

No exceptions

There were six files reviewed (two open and four closed). In all six files the suicide screening happened during intake using the CINS Intake Assessment form and the Suicide Risk Evaluation (SRE). All screenings were reviewed and signed by a supervisor. All youth were placed on the appropriate level of supervision based on the screening results. Two of the youth were placed on sight and sound supervision. These two youth were seen and assessed by a qualified mental health professional within twenty-four hours and placed on normal supervision levels. Both youth had documentation of thirty-minute observations maintained the entire time on suicide precautions. All observations logs were signed by the supervisor and clinical director.

### 4.03: Medication

Provider has a written policy and procedure that meets the requirement

<table>
<thead>
<tr>
<th>RATING</th>
<th>YES</th>
<th>NO (explain)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

No exceptions
# Quality Improvement Review

**LSF/NW-Hope House – October 2-3, 2019**  
Lead Reviewer: Ashley Davies

## Quality Improvement Indicators

<table>
<thead>
<tr>
<th>Rating</th>
<th>Explain</th>
<th>Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation</th>
<th>Notes</th>
<th>Summarize Findings Based on Completed Worksheets</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Satisfactory</strong></td>
<td></td>
<td>Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Deficiency Identified</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>No Eligible Items For Review</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>No Practice</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Not Applicable</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**for Indicator 4.03**

The agency has a policy in place titled Medications that was last reviewed October 3, 2019 by the regional director.

**RATING**

- [ ] Satisfactory  
- [ ] Deficiency Identified  
- [ ] No Eligible Items For Review  
- [ ] No Practice  
- [ ] Not Applicable

The agency has a list of staff who are trained to supervise the administration of medications. The registered nurse (RN) is listed as one of the Super Users of the Pyxis Med-Station, as well as, the residential services manager. The RN distributes any needed medications when onsite. Trained youth care specialists (YCS) with access to the Pyxis Med-Station distribute medications when the RN is not onsite. Trained YCS complete an inventory every shift of controlled medications. This inventory is documented on the youth’s Medication Distribution Log (MDL). A perpetual inventory is maintained on each medication as it is given and documented on the MDL. Over the counter (OTC) and prescription medications are stored in the Pyxis Med-Station which is stored in a locked room accessible only to authorized staff. Oral medications are stored separately from topical medications. The shelter has a medication refrigerator that is locked, and the temperature is set to 46 degrees. The RN trains all staff on the use of the Pyxis Med-Station, Epi Pens and the medication administration process at hire. Training documents were located in the medication room. Medications are verified at admission by contacting the pharmacy.

At the time of the review the shelter did not currently have a nurse. The previous nurse resigned August 31, 2019. A new nurse was hired but resigned during the first twenty-one hours of training. The agency has the position advertised again and the shelter was in the process of trying to hire another nurse for the position.
Quality Improvement Review

<table>
<thead>
<tr>
<th>Quality Improvement Indicators</th>
<th>Rating</th>
<th>Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Summarize Findings Based on Completed Worksheets</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)</td>
<td></td>
</tr>
</tbody>
</table>

Reports reviewed show that there were no open discrepancies in the Pyxis MedStation. Staff are aware that discrepancies should be cleared at the end of each shift. A monthly review of Pyxis reports is conducted by the RN. The shelter currently does not accept prescribed injectable medications. There is locked file cabinet in the kitchen where sharps are stored. All sharps are inventoried weekly.

4.04: Medical/Mental Health Alert Process

Provider has a written policy and procedure that meets the requirement for Indicator 4.04

☑ YES ☐ NO (explain)

The agency has a policy in place titled Medical/Mental Health Alert Process that was last reviewed October 3, 2019 by the regional director.

No exceptions

RATING ☒ ☐ ☐ ☐ ☐

There were four files reviewed (three open and one closed). The shelter utilizes a color-coded system for medical and mental health alerts. All files contained color-coded alert dots that corresponded with identified alerts. Alerts were also appropriately documented on the dry erase board (upstairs and downstairs in the shelter) and in NoteActive. Any dietary alerts are documented on a form located in the kitchen. Staff were provided sufficient information to recognize and respond to the need for emergency care.

No exceptions

4.05: Episodic/Emergency Care

Provider has a written policy and procedure that meets the requirement

☑ YES ☐ NO (explain)

No exceptions
## Quality Improvement Review

**LSF/NW-Hope House – October 2-3, 2019**  
**Lead Reviewer: Ashley Davies**

### Quality Improvement Indicators

<table>
<thead>
<tr>
<th>Rating</th>
<th>Explain</th>
<th>Review Based Upon</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Document Source: Interview/Surveys, Observation, and/or Type of Documentation</td>
<td>Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Summarize Findings Based on Completed Worksheets</td>
<td></td>
</tr>
</tbody>
</table>

#### for Indicator 4.05

The agency has a policy in place titled Episodic/Emergency Care that was last reviewed October 3, 2019 by the regional director.

**RATING**

<table>
<thead>
<tr>
<th></th>
<th>☒</th>
<th>☐</th>
<th>☐</th>
<th>☐</th>
<th>☐</th>
</tr>
</thead>
</table>

The program has a practice in place for off-site emergency medical situations. They have not had any off-site medical situations in the last six months. All staff have current training in CPR/First Aid. There are first aid kits located in the kitchen, YCS Office upstairs and downstairs, and the vehicles. The contents of all first aid kits are checked monthly by the nurse. The shelter has two sets of knife-for-life and wire cutters. One set is located in a box, in the closet of the nurse’s office. The second set is located in a box, in a drawer in the upstairs YCS office. A seatbelt cutter, window punch, and air bag deflater are located in each vehicle.

No exceptions