



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

Review of LSF SE- Lippman

on 11/30/2016

## CINS/FINS Rating Profile

### Standard 1: Management Accountability

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

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

### Standard 3: Shelter Care

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

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

### Standard 2: Intervention and Case Management

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

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

### Standard 4: Mental Health/Health Services

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

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

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

### Rating Definitions

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

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

### Review Team

#### Members

**Marcia Tavares, Lead Reviewer, Consultant-Forefront LLC**

**Jason Kasten, Supervisor, Arnette House**

**Gabriel Medina, QI Monitor, Department of Juvenile Justice**

**Katherine Raskob, Counseling Services Coordinator, Florida Keys Children Shelter**

**Mark Shearon, Chief Compliance Manager, Arnette House**

### Persons Interviewed

- |   |  |   |
|---|--|---|
| <input checked="" type="checkbox"/> Chief Executive Officer | <input checked="" type="checkbox"/> Executive Director     | <input type="checkbox"/> Chief Operating Officer            |
| <input type="checkbox"/> Chief Financial Officer            | <input checked="" type="checkbox"/> Program Director       | <input checked="" type="checkbox"/> Program Manager         |
| <input type="checkbox"/> Program Coordinator                | <input checked="" type="checkbox"/> Direct- Care Full time | <input checked="" type="checkbox"/> Direct-Care Part Time   |
| <input type="checkbox"/> Direct-Care On- Call               | <input type="checkbox"/> Volunteer                         | <input type="checkbox"/> Intern                             |
| <input checked="" type="checkbox"/> Clinical Director       | <input checked="" type="checkbox"/> Counselor Licensed     | <input checked="" type="checkbox"/> Counselor Non- Licensed |
| <input checked="" type="checkbox"/> Case Manager            | <input type="checkbox"/> Advocate                          | <input type="checkbox"/> Human Resources                    |
| <input type="checkbox"/> Nurse                              |  |   |
| 2 Case Managers   | 0 Maintenance Personnel                                    | 2 Clinical Staff  |
| 2 Program Supervisors                                       | 0 Food Service Personnel                                   | 0 Other   |
| 1 Health Care Staff   |  |   |

### Documents Reviewed

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Accreditation Reports                        | <input checked="" type="checkbox"/> Fire Prevention Plan             | <input type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records        | <input type="checkbox"/> Visitation Logs            |
| <input checked="" type="checkbox"/> CCC Reports                       | <input type="checkbox"/> Key Control Log                             | <input checked="" type="checkbox"/> Youth Handbook  |
| <input checked="" type="checkbox"/> Logbooks                          | <input checked="" type="checkbox"/> Fire Drill Log                   | 3 # Health Records                                  |
| <input checked="" type="checkbox"/> Continuity of Operation Plan      | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 2 # MH/SA Records                                   |
| <input checked="" type="checkbox"/> Contract Monitoring Reports       | <input checked="" type="checkbox"/> Table of Organization            | 17 # Personnel Records                              |
| <input type="checkbox"/> Contract Scope of Services                   | <input checked="" type="checkbox"/> Precautionary Observation Logs   | 9 # Training Records                                |
| <input checked="" type="checkbox"/> Egress Plans                      | <input checked="" type="checkbox"/> Program Schedules                | 2 # Youth Records (Closed)                          |
| <input checked="" type="checkbox"/> Fire Inspection Report            | <input type="checkbox"/> Telephone Logs                              | 5 # Youth Records (Open)                            |
| <input type="checkbox"/> Exposure Control Plan                        | <input checked="" type="checkbox"/> Supplemental Contracts           | 3 # Other   |

### Surveys

3 Youth                      3 Direct Care Staff

### Observations During Review

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Intake                                    | <input checked="" type="checkbox"/> Posting of Abuse Hotline         | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input checked="" type="checkbox"/> Program Activities             | <input type="checkbox"/> Tool Inventory and Storage                  | <input checked="" type="checkbox"/> Facility and Grounds       |
| <input 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 type="checkbox"/> Meals                                 |
| <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input type="checkbox"/> Youth Movement and Counts                   |  |
| <input type="checkbox"/> Medication Administration                 | <input checked="" type="checkbox"/> Staff Interactions with Youth    |  |

### Comments

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

Rating Narrative

## Strengths and Innovative Approaches

### Rating Narrative

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

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

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

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

## Standard 1: Management Accountability

### Overview

#### Narrative

LSF Southeast operates both the Lippman Youth Shelter (residential) and Broward Family Center (non-residential) CINS/FINS Program in Broward County. The CINS/FINS program has a management team that is comprised of: an Executive Program Director (ED); a Shelter Services Manager; a Licensed Mental Health Counselor who is the Clinical Supervisor (Counselor III); and a Senior Administrative Assistant. At the time of the review, the program had two vacant positions for full-time Youth Care staff, one of which was filled during the visit.

The ED reported there were no specific issues or problems within the program at the time of the QI visit. Although there has been significant turnover of direct care staff, especially in the shelter program. The management team is stable. Since the last QI review, the program purchased a new camera system around September/October 2016 with personal agency funds. In response to the findings of the last QI review, the program hired a new Administrative Assistant to assist with the maintenance of staff training files and monitoring of staff training. Also, staff is apprised of programmatic corrective action plans which are visibly posted on a board at the administrative office.

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

The program has an Annual Training Plan for FY 2016-2017. Each year the plan is reviewed, revised, and approved. The plan includes mandatory training for all staff including orientation training for new hires and an in-service component. Employees receive ongoing training from Skill Pro, local providers, and the Florida Network. Each employee has a separate training file that contains a training plan and supporting documentation for training received. Annual training is tracked according to the employee's date of hire.

LSF Broward maintains several interagency agreements with over thirty agencies that ensure a continuum of services for the youth and families. The program also has an Outreach Targeting Plan and a strong outreach component with participation of all program staff and emphasis on the designated high crime zip coded areas as well as low performing schools.

The Department of Children and Families has licensed Lippman Youth Shelter as a Child Caring Agency, with the current license in effect until June 27, 2017.

### 1.01 Background Screening

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a Policy and Procedures (#1.01 "Background Screening of Employees and Volunteers") that was last revised on September 18, 2015 and approved on August 31, 2016. The policy and procedures comply with the requirements for background screening of all Department of Juvenile Justice employees, contracted providers, and volunteers as well as anyone else with direct and unsupervised access to youth.

New screenings are required to be conducted prior to the hiring of employees or volunteers and the screenings are conducted using Live Scan. Prospective employees and volunteers are required to complete the appropriate forms required for fingerprinting. In addition to the DJJ Background Screening, the provider also conducts driver's license screening for new hires, quarterly driver's license screening

for existing staff, annual local municipality and county screenings, and a drug screening upon hire and randomly thereafter. Employees and volunteers are re-screened every 5 years of employment. The agency updates the Affidavit of Compliance with Good Moral Character Standards annually and submits the Affidavit with corresponding attachments to DJJ by January 31st.

A total of seventeen (17) personnel files were reviewed for eleven (11) new hires, two (2) five-year re-screened staff, and four (4) interns. All of the eleven (11) new hires were screened and received an eligible screening result prior to their hire dates. Similarly, the four (4) interns utilized by the provider during the review period were background screened and eligible screening results were obtained prior to their volunteer start dates.

The provider had two (2) eligible five-year re-screenings during the review period. The 5-year re-screenings were submitted to DJJ Background Screening unit and the results were obtained prior to the employees' five year anniversary dates.

Proof of the faxed submission of the Annual Affidavit of Compliance with Good Moral Character Standards was provided along with evidence showing it was sent to DJJ on January 6, 2016 prior to the January 31st deadline.

No exceptions were noted for this indicator as of the time of the QI visit.

#### 1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

##### Rating Narrative

The program has a Policy and Procedures (#1.02 "Provision of an Abuse Free Environment" approved on August 31, 2016) that includes procedures for: 1) ensuring a code of conduct that prohibits physical abuse, profanity, threats or intimidation, and neglect; 2) mandating the reporting of all allegations/suspected abuse to the abuse hotline; 3) filing of grievances; and 4) requiring management to take immediate actions to address incidents of physical and/or psychological abuse or staff's failure to adhere to the agency's behavioral policy.

The agency's Code of Conduct is communicated to new staff during agency orientation. New staff receives a copy of the agency's Personnel Policies and Procedures Manual that includes a description of its expectation in integrity in service delivery. An acknowledgement of receipt is signed by the employee and a copy is maintained in the employee's personnel file. In addition, new staff signs the Staff/Volunteer Code of Conduct in agreement with the rules. Corporal punishment is prohibited and shelter staff is required to sign a Corporal Punishment Acknowledgement statement indicating receipt and knowledge of the policy.

Staff's responsibilities and the agency's protocol for reporting child abuse are clearly outlined in the program's procedures. New staff receives training during orientation and are informed to immediately report all allegations of child abuse or suspected abuse to the Abuse Hotline. All reports of abuse are documented in the progress notes of the youth's file and a copy of the faxed report is placed in a binder.

Youth are informed of the agency's grievance process during intake and a copy of the grievance procedures is included in the Resident Handbook that is provided to each youth. A grievance box and forms is located in the facility and is accessible to youth.

The Abuse Hotline telephone number is visibly posted in the shelter in the lobby, counseling office hallway, the YCS monitoring station area, and in each youth's bedroom. In addition, the abuse hotline phone number is listed in the Resident Handbook that is reviewed with youth and parents during admission. Also included in the handbook are the youth's rights, information on the grievance process, and behavioral expectations. The youth and parent/guardian sign the orientation checklist acknowledging receipt of the handbook and their understanding of the information provided during orientation. This form was located in the three files that were reviewed.

A total of twenty calls were made to the Abuse Hotline by the shelter staff between June and November 2016. A copy of the reporting form for each call was kept in an Abuse Hotline Report log binder. Each report included the name of the Abuse Hotline worker, worker's ID#, and the name and title of program staff that made the report. None of the abuse allegations were against agency staff. Per the Senior Administrative Assistant, none of the direct care staff were written up or disciplined for any incident abuse, neglect, and/or excessive use of force during the review period.

The program reported two grievances during the review period. One of the grievances was a complaint by youth about not getting enough food; the other grievance was a 3-page letter written by youth regarding disagreement with their behavioral consequence. Both grievances were addressed by the shelter manager and resolved with the youth involved.

None of the three staff surveyed indicated that working conditions at the shelter were poor; responses by staff were: 1-very good, 1- good, and 1- fair. None of the three staff reported hearing or observing a co-worker using profanity, intimidation, or humiliation when interacting with youth.

The three youth surveyed said they knew about the grievance process. All three youth surveyed also indicated they knew about the abuse hotline and were aware of the location of the telephone number. Similarly, the three youth also indicated that adults were respectful when talking to youth and felt safe in the shelter. None of the youth reported hearing staff threaten them or other youth.

No exceptions were noted for this indicator as of the time of the QI visit.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

#### Rating Narrative

Agency has a very clear and precise policy and procedure when it comes to Incident Reports. The LSF Incident Report that is used captures all contractually required information. The policy was reviewed and updated last on August 31, 2016.

Incidents are documented on an agency incident reporting form that captures pertinent information including date, time, location; client status; participants/witnesses; individuals notified; corrective action and follow-up; and signatures of individuals who reviewed the incident. An Incident Reporting Cover Sheet that summarizes the incident is attached to the Incident Report Form and emailed/faxed to Agency's Statewide Director of QA and Compliance for data entry.

There were 11 CCC reportable incidents and 62 in-house incident reports reviewed; all reports were filled out appropriately and all contacts were made within the required time-frame except for one CCC report that was outside the 2-hour reporting time-frame.

The Agency has a CCC log book that shows the time and date that the CCC was called and whether the call was accepted or not. However, the incidents are documented in the log book but the phone calls to contact the CCC, parent and/or law enforcement is not listed within the log book. One (1) of the nine (9) CCC reports was not documented in the logbook. All the reports were reviewed and signed off by the supervisor and follow-ups were listed on the reports. The Agency follows its Policies and Procedures accordingly.

#### Exceptions:

One of the reportable CCC incidents was reported outside of the required two hour reporting period.

And another CCC report was not logged in the program logbook.

### 1.04 Training Requirements

Satisfactory

Limited

Failed



Rating Narrative

Agency has a very clear and precise policy and procedures that mirrors that of the Florida Network. It covers all the requirements of the QI Indicator 1.04. The Policy was updated and reviewed last on August 31, 2016.

The agency maintains an individual training file for each staff which includes manually written training logs, supporting training certificates, sign-in sheets, and agendas for each training attended. The agency hired a full-time employee to monitor and maintain the training files. All of the files reviewed were very neat and easy to navigate, and if there is a question regarding the file, the staff is quickly able to locate the information needed.

Five first year employee training files were reviewed for two part-time and three full-time staff. All five employees are well on target for completing the required training hours, with four of the employees already exceeding those hours. One of the files reviewed is a part-time staff that is just coming out of her 120 day period on November 25, 2016 and has not completed her CPR/First Aid but is scheduled to do so in December.

Two Clinical Staff training files were reviewed and both have completed the Non-Licensed Mental Health Clinical Staff Training for Assessment of Suicide Risk. The training is documented on the appropriate form and kept in their personnel files. The two Clinical Staff are still within their 120 day period and are missing some of the required training but still have ample time to finish them.

There were four in-service training files reviewed and all the staff met the required training within the required time-frame. Three of the in-service training files were for clinical staff and each staff completed their Non-Licensed Mental Health Clinical Staff training which is kept in their personnel files observed by this reviewer. One of the in-service files was a Youth Care Worker who completed all required training and has met the annual required training hours.

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

#### 1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedures (P&P) , #1.05 – Analyzing and Reporting Information that was last reviewed September 18, 2015 and approved August 31, 2016. In addition, there is a comprehensive agency-wide Performance Quality Improvement (PQI) Plan (2015) that includes detailed procedures to collect, review, and reports various sources of information to identify patterns and trends. Per the procedures, findings are reviewed by management and communicated to staff and stakeholders.

The program has procedures in place for analyzing and reporting data. Although P&P #1.05 does not outline the specific procedures, they are documented in the agency's 2015 PQI plan. The program assigns individual staff as Chairpersons to represent committees responsible for the collection of various data required by the indicator. A formal list was not maintained but the residential and non-residential program managers provided the names of the Chairs to the Reviewer onsite. The Chairs are responsible for collecting data from the programs on a monthly basis for Case Record reviews; Incidents, Accidents, and Grievances; Customer Satisfaction Surveys; and Outcome Data. Data received is entered into the agency's online database.

NetMIS data is emailed to the management staff on a weekly basis for review and follow-up. The data is compiled by the agency's CQI Director into reports that includes a summary of the incidents/accidents, grievances, and fire drills that occurred during the quarter, summary of case record reviews, reporting of performance measurements for the quarter, number and types of training provided to staff, and satisfaction surveys completed. The program reviews the reports at monthly management and staff meetings. The Executive Director also posts outcomes data and corrective action plans on a board, which is accessible to staff, at the Administrative office.



### Quarterly Case Record Reviews

The provider maintains a binder with monthly case record reviews for each program. A total of 183 cases were reviewed between June and October 2016. Documentation included the checklists used during the peer record review, documenting deficiencies. A report is generated for each review. Documentation of case record reviews was observed for at least on a monthly basis by the programs. A review of the agendas for monthly staff meetings held since June 2016 showed evidence of discussion of case record reviews for four of the six months reviewed.

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

Data regarding the number of incidents/accidents and grievances is entered into the agency's database that captures a variety of data for all of the programs statewide. A copy of the data entered for the review period was reviewed. A total of 47 incidents were reported from June-October 2016 by the residential CINS/FINS program. Per the provider's procedures, incidents/accidents and grievances are reviewed at staff meetings. A review of the agendas for monthly staff meetings held since June 2016 showed evidence of discussion of incidents, accidents, and grievances for five of the six months reviewed.

The CINS/FINS residential program reported only one grievance (July 2016) per the QI tracking report for the review period; however, the review of the program's grievance reports showed two grievances were submitted, one in July and one in August 2016.

### Customer Satisfaction Data

The programs collect customer satisfaction survey data monthly and enter the number completed each month into the agency's database. For the review period, a total of 209 customer satisfaction surveys were completed by the programs, resulting in a 96% and 49% satisfaction rate for the residential and non-residential program, respectively. A review of the agendas for monthly staff meetings held since June 2016 showed evidence of discussion of client satisfaction surveys for the six months reviewed.

### Outcome Data

Florida Network Outcome's data is entered, tracked and documented in the agency's database. The data was reviewed onsite for the period January-October 2016. There is evidence of this information being shared with program staff at staff meetings and the outcomes are posted for staff to view at the Administration office. A review of the agendas for monthly staff meetings held since June 2016 showed evidence of discussion of outcomes data for five of the six months reviewed.

### NetMIS Data Review

Monthly review of NetMIS Data is completed as required by Indicator 1.05. The provider communicates NetMIS data to management staff regularly via email. Staff meeting minutes do not specifically include a discussion of the NetMIS data reports, actions implemented, or follow-up needed to address any deficiencies.

#### **Exception:**

Per the ED, NetMIS data quality reports are disseminated to the Program Manager monthly; however, there is no evidence of how this is communicated to staff and staff meeting minutes do not specifically include a discussion of the NetMIS data reports, actions implemented, or follow-up needed to address any deficiencies.

### **1.06 Client Transportation**

Satisfactory

Limited

Failed

Rating Narrative

The agency has a very clear and precise policy and procedure that deals with Client Transportation. The Policy was reviewed and updated on August 31, 2016.

The procedure addresses the following: 1) Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle; 2) Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy; 3) Third party is an approved volunteer, intern, agency staff, or other youth; and 4) Documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.

Three sets of van logs were reviewed for the last six months. The log sheets include drivers' names, dates, times, mileage, number of passengers, and destination in accordance with the standard set forth by the Florida network.

The agency's administrative staff reviews and approves all drivers for the agency. The agency has a copy of the driver's licenses for all staff and they are all on the agency's insurance policy. Volunteers and interns are not allowed to drive agency vehicles but may be included in the staff ratio when it comes to transporting youth. The van logs do not show the approval of the Supervisor for a single transport but it is documented in the logbook at time of the transport.

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

#### 1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has a very clear and precise policy and procedure regarding outreach services that mirrors the Florida Network indicator. The policy and procedures reviewed were last updated on August 31, 2016.

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

The agency has agreements with four mental health services, four substance abuse services, two truancy services, two safe place sites, four CINS/FINS service centers, two employment services, seven educational internships, five medical services, and ten support services. In the last three months, the agency attended twelve outreach activities in the community to: church, school open houses, a Behavior Health Resource Fair, City Fire Rescue Centers, Inaugural Attendance Symposium, and the Lighthouse Point. All of these outings were used to spread the word about the agency's mission and Safe Place information.

There were four events reviewed for this period. Three of the four events were Circuit 17 DJJ Advisory Board meetings in which the staff received email notices of the meetings and received an agenda upon showing up at the meeting. The other event reviewed was a Safe Place meeting that was held at the Pompano Beach Fire Rescue which did not have an agenda but was a site visit for Safe Place.

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

## Standard 2: Intervention and Case Management

### Overview

#### Rating Narrative

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

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

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

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

During the QI review, a total of 7 case files were reviewed. A total of 3 open residential, 3 open non-residential, and 1 recently closed non-residential file. Two of the non-residential case files, 1 open and 1 closed, were reviewed specifically for Standard 2.06.

### 2.01 Screening and Intake

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy and procedures that addresses all of the key elements of the CQI indicator. The policy manual was last updated on August 31, 2016 and was signed by the Executive Director, the Clinical Director and the Residential Services Manager.

The provider's procedures include:

- Referral for services: attempts for contact with the youth/family begin within 7 days after receiving referral in order to complete screening.
- An initial screening which gathers information pertaining to the client's situation, presenting problem, immediate needs, and whether or not the youth is eligible for CINS/FINS Services. If the screening determines an emergency does not exist, then the youth may be placed on a wait-list.

- Upon acceptance for services, the Intake, Brief FAM and Needs Assessment are scheduled.
- Non-residential: Needs Assessment is initiated within 72 hours of Intake completion and completed within 2-3 sessions or visits.
- Residential: full intake process is to be completed which includes NetMIS packet, Risk Factors and Needs Assessment initiated within 72 hours. Needs Assessment must be completed within 7 days of intake.
- All clients are provided with information related to available services, right and responsibilities of youth and parent/guardians, grievance procedures, and possible actions occurring through involvement with CINS/FINS services. Each family receives a copy of the CINS/FINS handbook.
- If there is immediate crisis, law enforcement is contacted to ensure an immediate evaluation or the parent may be advised to transport youth to an appropriate facility for evaluation.
- If a youth is found eligible for non-residential services, the youth will be assigned to the appropriate counselor. Case assignment should occur within 3 business days of completing the screening. The Counselor has 30 days to make contact with the family. If after 3 attempts (phone, letter, home visit) with no contact, the counselor may close the screening only.
- If staff has a question regarding the eligibility of a youth they may utilize the on-call cell system.

Three (3) open residential case files were reviewed. All 3 case files had a screening for eligibility conducted within 7 calendar days of referral. All 3 case files displayed evidence within the case file that suggested that parents/guardians were informed of available service options, rights and responsibilities and parent/guardian brochure, grievance procedures, and possible actions occurring through involvement with CINS/FINS. All 3 case files had a CINS/FINS Intake completed within the appropriate time-frame.

Three non-residential open case files were reviewed. All 3 case files has a screening for eligibility conducted within 7 calendar days of referral. All 3 case files displayed evidence within the case file that suggested that parents/guardians were informed of available service options, rights and responsibilities and parent/guardian brochure, grievance procedures, and possible actions occurring through involvement with CINS/FINS. All 3 case files had a CINS/FINS Intake completed within the appropriate time-frame.

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

## 2.02 Needs Assessment

Satisfactory

Limited

Failed

### Rating Narrative

The agency has a written policy and procedures that addresses all of the key elements of the CQI indicator. The policy manual was last updated on August 31, 2016 and was signed by the Executive Director, the Clinical Director and the Residential Services Manager.

The agency's procedures include:

- Residential: Completion of a Needs Assessment that is initiated within 72 hours of admission.
- Non-residential: Completion of Needs Assessment that should be initiated and completed within 2-3 face to face contacts following intake or updated if most recent assessment is over 6 months old.
- Exceptions are documented.
- Completion of Needs Assessment by Bachelors or Masters level staff. Needs Assessment must have supervisory review signature upon completion.
- If a youth is identified as having suicide risk behaviors, youth is referred for an Assessment of Suicide Risk

conducted by non-licensed staff under the direct supervision of a Licensed Mental Health Professional or a Licensed Mental Health Professional.

Three open residential case files were reviewed. All 3 case files had a Needs Assessment initiated within 72 hours of admission. All 3 case files were completed by a BA or MS level staff member. All 3 case files had a supervisor review signature. Two of three case files were not identified as risk of suicide and did not need a referral for assessment of suicide risk. One of the three case files was identified as having an elevated suicide risk due to a history of multiple Baker Acts and an assessment of suicide risk was completed. The suicide assessment findings were recorded as low. The assessment was signed by a licensed mental health professional.

Three open non-residential case files were reviewed. All 3 case files had a Needs Assessment completed within 2-3 face to face sessions and were completed by BA or MS level staff. Signature of qualified supervisor was completed on all assessments. All 3 case files did not have an elevated risk for suicide therefore there was not a need for further assessment.

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

### 2.03 Case/Service Plan

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy and procedures that addresses all of the key elements of the CQI indicator. The policy manual was last updated on August 31, 2016 and was signed by the Executive Director, the Clinical Director and the Residential Services Manager.

The provider's procedures include:

- Implementation of a service plan that is developed within 7 days of completion of the needs assessment.
- Service plan reviews with the youth and/or family every 30 days that is documented in the case file.

The provider's service plan includes:

- A brief statement of the presenting problem(s) which are bringing the youth into services with the agency
- A goal to address a need identified in the needs assessment
- At least one measureable objective to achieve that goal
- The location where the objective will be reviewed or completed
- The person responsible for achieving or reviewing the objective
- A target date for when that objective is to be completed
- The type of intervention to accomplish the objective
- How many sessions, the time-frame of estimated completion, and how long per session is estimated to complete the goal

Additionally, service plans are required to be signed and dated by the Counselor, the youth and by at least one parent/guardian if present. Needs of the youth and family are identified, discussed and recorded on the service plan. Recommendations in regards to services are made: these can be provided by the agency or a referral can be made to an outside resource. The agency ensures nondiscrimination and equal opportunity in service delivery in accordance with state and federal laws.

Three open residential case files were reviewed. All 3 cases had case service plans that were developed within 7 working days of completion of the Needs Assessment. All 3 cases were individualized and prioritized needs and goals identified by the Needs Assessment. All 3 cases included service type, frequency, location, person(s) responsible, and target dates for completion. All 3 case files did not have actual completion dates recorded due to case files being open and goals had yet been met. All 3 cases had signatures of youth, parent/guardian, counselor and date plan was initiated. Two of three cases did not require a 30 day review due the review not being due yet. One of three case service plans did not require a 30 day review due to a service plan update being completed at the 30 day review requirement.

Three non-residential open case files were reviewed. All 3 case files had a case service plan that was developed within 7 working days of the completion of the Needs Assessment. All three service plans were individualized and prioritized the client's need(s) and goal(s) that were identified during the Needs Assessment. All service plans reviewed contained service type, frequency, and location. All 3 service plans reviewed contained person(s) responsible, actual completion dates, signatures of parent/guardian, youth, counselor and supervisor. All 3 plans reviewed contained the date that it was initiated. All 3 case service plans did not contain actual completion dates due to goals/objectives proving yet to be resolved. One of 3 case service plans had service plan reviews completed on time.

**Exception:**

Two of three non-residential case service plan reviews were observed to be late. One case file reviewed contained a review that was 3 days late and the other contained a review that was 11 days late. Explanations as to why the service plans were late were not recorded in the case file case notes.

**2.04 Case Management and Service Delivery**

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last updated August 31, 2016 and was signed by the Executive Director, the Clinical Director and the Residential Services Manager.

The provider's procedures include:

- Case management: coordination of services utilizing appropriate resources for children and their families
- Assignment of a counselor/case manager who will follow client's case and ensure delivery of services through direct provision or referral

The provider's case management process incorporates a variety of activities that includes but are not limited to:

- Coordinating referrals to services based upon the on-going assessment of the child/family's problems and needs
- Coordinating service plan implementation
- Monitoring child's/family's progress in services
- Providing support for families
- Monitoring out-of-home placement, if necessary
- Making referrals to the case staffing committee, as needed, to address the problem and needs of the child/family
- Recommending and pursuing judicial intervention in selected cases



- Accompanying the child and parent(s) to court hearings and related appointments, if applicable
- Continued case monitoring and review including court orders
- Case termination with follow-up.

Three open residential case files were reviewed. All 3 cases had a case manager/counselor assigned to the youth/family. Two of the three cases did not require a referral and this was marked as non-applicable. The one case that required a referral for medical purposes had a referral made accordingly. One of 3 cases did require the need to monitor out-of-home placement due to the client being court ordered to reside at the shelter and one case required the need to coordinate services due to the client working with outside agencies. All 3 case files demonstrated staff monitored youth/family progress in services and displayed evidence that support was provided to families. None of the 3 case files were applicable for case termination notes or 30/60 day follow-ups due to all clients being currently open within the shelter.

Four non-residential case files were reviewed for one recently closed case file and three open case files. The closed case file was only reviewed regarding items that applied: referral to case staffing, court hearings, court orders and termination procedures. All 3 open case files had a case manager/counselor assigned and the counselors established referral needs and coordinated referrals to services appropriately. Referral forms to connect client/family to resources were found in the files. All three open case files reviewed displayed evidence that service plan coordination was implemented, that the youth/family's progress was monitored, and that support was provided. Two of four case files reviewed required referrals to the case staffing and this was completed appropriately. One of the two cases referred to case staffing required accompaniment to court hearings due to a court hearing scheduled within the time-frame of this review. This case file also displayed evidence that case monitoring and the review of court orders occurred as needed.

One closed case file was reviewed in relation to termination procedures. This case file contained case termination notes; however, at the time of review the 30/60 follow-up was not due.

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

## 2.05 Counseling Services

Satisfactory

Limited

Failed

### Rating Narrative

The agency has a written policy and procedures that addresses all of the key elements of the CQI indicator. The policy manual was last updated on August 31, 2016 and was signed by the Executive Director, the Clinical Director and the Residential Services Manager.

The agency's procedures include the following:

- All referrals are screened for eligibility and eligible youth begin the service delivery process by participating in the CINS/FINS Intake Assessment process in order to identify suicide risk and referral issues.
- Non-residential: Upon referral, or within a service time period, a client can be referred to a shelter placement if client is a runaway, has perpetrated violence in the home or engaged in any other form of domestic violence. A client can also be referred to the shelter for a brief "cooling off/respice." If agency's shelter is at maximum capacity, the client will be referred to a shelter in the area which has a formal, written inter-local provider agreement. The program targets youth who are at risk youth with multiple risk factors within three or more of the following four domains: family, school, peers, and individual antisocial behavior as identified on the DJJ risk factors questionnaire.
- Non-residential and Residential: prioritize youth who have engaged in domestic violence in an attempt to



keep them from being placed in a detention facility and from entering the juvenile justice system.

§ Supervisory approval is required for non-residential cases that extend 12 sessions.

- Suicide risk is monitored throughout service delivery.

At a minimum the provider's counseling services shall:

- Reflect all case files for coordination between presenting problem(s), needs assessment, service plan, service plan reviews, case management services and follow-up
- Maintain individual case files on all clients and adhere to all laws regarding confidentiality
- Maintain chronological case notes on the client's progress
- Maintain on-going internal process that ensures clinical review of case records, client management and staff performance.

A total of 3 open residential case files were reviewed. All 3 cases received individual and/or family counselor as appropriate and necessary in accordance with the case/service plan and case files contained case notes for all counseling services provided and progress was documented. All three cases did receive group counseling services; however, not all services were documented in the case file and the file displayed only a few group session case notes in the case file. Lutheran services was able to display evidence of the consistent offering of group via their group session log book as well as group notes being recorded within the residential log book. Groups recorded in the residential log book were conducted by counseling interns. Groups recorded in the group log book were conducted by the counselors. All 3 case files contained records that provided evidence that ensured clinical reviews of case files were being completed.

Three open non-residential case files were reviewed. All 3 case files displayed evidence that youth and families received counseling services in accordance with the case/service plan. All 3 case files received individual/family counseling and displayed evidence that the youth's presenting problems were addressed in the Needs Assessment, service plan and service plan reviews. All 3 case files had case notes maintained for all counseling services and documented progress as well as on-going internal processes for review of clinical records.

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

## 2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

### Rating Narrative

The agency has a written policy and procedures that addresses all of the key elements of the CQI indicator. The policy manual was last updated on August 31, 2016 and was signed by the Executive Director, the Clinical Director and the Residential Services Manager.

The provider's procedures include the following:

- Case Staffing Committee (CSC) is also referred to as TURN Committee- for Truant, Ungovernable, and Runaway Network.
- Case Staffing Committee meetings must be held within 7 working days after the receipt of a written request is received.
- Meetings are scheduled as needed and within the specified time-frames; locations are convenient to the youth, family and committee members.

- All coordination and court work including required court paperwork is the responsibility of the case manager or other designee of the CINS/FINS service provider.
- Upon receipt of the completed petition and pre-disposition report, it is the responsibility of the DJJ attorney to file the petition with the Clerk of Court in accordance with recommendations from the case staffing committee.
- The Clerk of Court issues a summons with the date, time and place of the court hearing and/or arraignment, and copy of petition. Summons is directed to: parents, legal custodian and actual custodian, child, guardian ad Litem (if applicable).
- Parent and child must admit to allegations and/or provide consent to the petition in order for a disposition hearing to be scheduled. If the allegations are denied, the case is set for an adjudicatory hearing.
- Court holds review hearings every 45 days after the disposition hearing. Additional review hearings can be held as needed but not less than 45 days after the date of the last review.
- Court cases will be closed if the client has complied with the case plans and court orders and no longer requires continued court supervision.
- Failure to comply results in the child remaining a Child in Need of Services.

A case staffing committee is held if: the family or child is not in agreement with the services or treatment offered; the parents or child will not participate in the services or treatment selected; the case manager needs additional assistance in developing a case plan; or if a parent/guardian requests a case staffing committee meeting. When requested by a parent/guardian, the request must be in writing and the staffing must be held within 7 working days of receipt of the written request. The youth and family must be notified by phone or in writing within 5 days of the case staffing meeting being scheduled.

The provider's case staffing meetings occur monthly and additional meetings can be scheduled including emergency case staffing. The outcomes and documentation of results of case staffing committee meetings must be maintained in each client's file and reviewed monthly by the Prevention/Intervention Manager. Clients receive copies of all documents that they sign or documents pertinent to their case. Written requests are sent to CINS/FINS Director and/or their designee. Committee members are notified by the director or designee. If a parental case staffing request is not scheduled within the guidelines due to unforeseen circumstances it is the responsibility of the CINS/FINS director or designee to provide an explanation in writing and schedule the meeting the next soonest available date.

Within 7 days of the CSC meeting, recommendations must be provided in writing to parent/guardian. A copy is also placed in the client file. The assigned case manager or designee will make every effort to meet with client and family within 7 days of the meeting to review recommendations and establish and/or update service plan. If a CINS Petition is recommended the assigned case manager or designee will prepare the petition and have it reviewed by the on-site administrator. The petition will then be filed with the DJJ General Counselor representing that District who will request a court date for the CINS hearing to occur. If the general Counselor approves the petition, the case manager or designee is responsible for getting it notarized, copied and resubmitted to him for signature and filing, and also for submitting a copy to the parents and child.

Two applicable case files were reviewed for 1 open and 1 recently closed case file. One of the two case files listed the parent as initiating the case staffing and the staffing was held within the appropriate time-frame. The two case files displayed evidence that the family was notified of the case staffing within 5 working days and notification was also provided to the committee within the appropriate time-frame. Although evidence was displayed that the family and case staffing committee were notified, one of the two case files reviewed did not have recordings of communications between the family and agency staff in the case notes of the scheduling of the case staffing; however, communications were displayed through copies of emails and text messages that were filed in the chart. Both case staffing meeting held had a local school district representative present, a DJJ representative and/or CINS/FINS provider as well as a mental

health representative.

There were no exceptions noted as of the time of the QI visit.

## 2.07 Youth Records

Satisfactory

Limited

Failed

### Rating Narrative

The agency has a written policy and procedures that addresses all of the key elements of the CQI indicator. The policy manual was last updated on August 31, 2016 and was signed by the Executive Director, the Clinical Director, and the Residential Services Manager.

The provider's procedures include the following:

- All case files are marked confidential.
- Each client case record includes chronological sheet and youth demographic data, program information, correspondence, service/treatment plans, needs information, case management information and other materials relevant to the case.
- All files are kept behind a locked door in a file cabinet that is marked confidential.
- Upon discharge the files are signed by a program manager and maintained in a locked file room in file cabinets marked confidential.
- Files are maintained by the Lead Program Assistant for a period of two years then transferred to a central storage unit and maintained for a period of 7 years.
- All files are maintained in a neat and orderly manner.

Three open residential case files and three open and one closed non-residential case files were reviewed. All 7 case files were clearly marked confidential. Case files are stored in locked filing cabinets that are also clearly marked confidential. If/when cases are transported, they are transported in an opaque, locked box marked confidential. All records reviewed were observed to be maintained in a neat and orderly manner.

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

## Standard 3: Shelter Care

### Overview

#### Rating Narrative

LSF Southeast operates its residential program, Lippman Youth Shelter, licensed by DCF through June 27, 2017 for 20 beds. The shelter provides residential services to youth in the Department of Juvenile Justice (DJJ) CINS/FINS program. At the time of the review, the shelter was providing services to 12 youth (7 DJJ and 5 DCF). Lippman provides staff secure and domestic violence respite services to youth. The program has adequate space for all activities and is equipped with a new 25 camera system that allows complete surveillance in and around the outside of the building.

The Lippman Youth Shelter has one dormitory wing separated by a hallway. Half of the bedrooms are used for male clients and the other half for females. Youth are separated based on census needs. An individual room close to the staff desk is utilized for clients with special alerts. The facility also has a large common area used for watching television, groups and other activities. The dormitory, kitchen, restrooms and common areas were clean during the tour of the facility. Youth are assigned closets that lock to store their personal belongings. Beds are lettered and youth are assigned to individual beds furnished with bed coverings and pillows. Youth have access to a large yard for outdoor activities. The youth admitted to the program are screened using the Network Youth Screening Form and the CINS/FINS Intake Form.

In addition to CINS/FINS, the shelter also serves foster care youth who meet the criteria for Staff Secure and Domestic Violence; however, the ED indicated that due to zoning issues, the program cannot take youth who are pending DJJ charges. During the review period, the program did not serve any probation respite, domestic minor sex trafficking, or staff secure youth.

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

### 3.01 Shelter Environment

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy and procedures that meets all required elements listed in the Florida Network Standards for Indicator 3.01. The policies are reviewed and signed on an annual basis and were last updated on August 31, 2016.

The shelter is comprised of a single wing with half of the rooms dedicated to male bedrooms (first four), half for female bedrooms (last four), and one room dedicated for clients with special alerts. Youth have individual beds that were lettered and numbered, and furnished with clean linens.

Separating the bedroom wing from the rest of the shelter is a large common area used for watching television, groups and other activities. The common area also contains a staff desk with live video monitoring, a first aid kit, the knife-for-life, and daily census board. Clinical offices, the med-station, laundry facilities, kitchen, and the dining area are all located on the other side of the shelter and all appeared clean during the tour. Clients have access to a large outdoor area for recreation including a basketball court and small weight lifting area. During the tour the shelter program director indicated that the outside area was recently cleared out and now provides a larger area for activities.

All health and safety inspections were completed by the provider during the past year. Copies of the current inspections were obtained during the visit.

All health inspections are current as of September 10, 2016 when the Department of Health completed the last health inspection which resulted in 4 citations: prepared food without labels; refrigerator without a thermometer; utensil drawer observed with debris; and employee restroom not self-closing. All concerns appeared to be corrected at time of review. The Fire Department completed the Annual Fire Safety inspection on June 2, 2016 with no deficiencies noted. The facility is equipped with knife-for-life, first aid kits (stored in the kitchen, med room and 2 facility vans), wire cutters and bio-hazard waste disposal bin(s). All fire safety equipment was current, tagged, and dated.

There is adequate lighting throughout facility. Youth have a safe lockable place to keep personal belongings.

Grounds appeared landscaped and well-maintained. The majority of bathrooms and shower areas were observed to be clean and functional. Laundry facilities and kitchen equipment all appeared clean and in good repair. Only one incident of graffiti was observed as a small scribbling on a youth dresser.

The facility's washer and dryer are operational and general lint collectors were clean upon review.

Youth are engaged in meaningful, structured activities seven days a week during wake hours. The daily schedule reflects at least 45 minutes of outside physical activity is provided during the weekdays and 2 hours on weekends.

Daily programming includes opportunities for youth to complete homework and journal writing. Daily programming schedule is publicly posted in multiple areas of the facility accessible to both staff and youth.

Faith-based activities were not listed on the program schedule but were listed on the staff schedule. Staff indicated youth are invited to participate in offsite church outings on Sundays.

**Exceptions:**

Shower in room 1 (special alert room) appeared to have mold/mildew at the base.

Room 6 ceiling appeared to have water damage on the ceiling and around the window. Some of the paint surrounding the window was bubbled up, peeling, and appears soft. During the review, both the Shelter Program Manager (SPM) and Executive Director (ED) indicated that there was a recent leak in the roof causing the water damage but has since been resolved. Documentation of the repair was not produced at time of visit.

Faith-based activities were not specifically listed on the client's daily schedule. It was however listed on the staff schedule for Sundays.

One dryer vent contained a large amount of lint.

Dead insects found in light fixtures in multiple locations.

Light fixture on side of the building is detached and free hanging from the wall. The SPM indicated that the light was recently broken by the landscaping crew and they should be fixing it shortly. The SPM called the landscaping crew during the review and left a message.

One fire extinguisher (Blue Van) was out of date as of June 2016.

**3.02 Program Orientation**

Satisfactory

Limited

Failed

Rating Narrative

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

**Network Standards for Indicator 3.02.** The policies are reviewed and signed on an annual basis and were last updated on August 31, 2016.

Each youth admitted to the facility receives a comprehensive client orientation handbook at time of intake as well as an orientation checklist review with a staff member within 24 hours. The orientation checklist includes: explanation of the program's disciplinary actions; grievance procedures; emergency/disaster procedures; contraband rules; layout of the facility; room assigned; daily schedule; and abuse hotline number. The youth orientation process also includes a discussion of the program's philosophy, goals, services and expectations.

At time of intake, youth and parents are provided a copy of the shelter handbook and sign the receipt of orientation handbook form.

Three residential files (2 current, 1 closed) were reviewed. All three files included a completed orientation checklist and all three contained the receipt of orientation form signed by the youth and parent.

The youth/parent orientation handbook was extremely detailed and covered all topics necessary as per the indicator.

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

### 3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedures that meets all required elements listed in the Florida Network Standards for Indicator 3.03. The policies are reviewed and signed on an annual basis and were last updated on August 31, 2016.

Clients are evaluated during intake and assigned a room based on history, status, exposure to trauma, behaviors and or gender, age, physical size, maturity level, history of physical or sexual aggression, susceptibility to victimization, medical and mental health concerns, physical disabilities and suicide risk factors. Youth deemed necessary to place on close watch or with risk associated behavioral concerns may be placed in a single room designated as the special alert room.

Three residential files were reviewed (2 open, 1 closed). All three files contained a copy of the CINS/FINS Intake Assessment which documents room assignment on page 2. The provider's protocol ensures classification of youth based on the youth's history, status and exposure to trauma, initial collateral contacts, initial interactions and observations of the youth, age, history of violence, susceptibility to victimization, presence of medical, mental or physical disabilities, suicide risk, and sexual aggression and predatory behavior.

**Exception:**

One file out of the three reviewed indicated that a client was assigned a room other than the designated special alert room after answering "yes" to question #1 on the initial suicide assessment form. Youth was not placed on constant sight and sound.

### 3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedures that meets all required elements listed in the Florida Network Standards for Indicator 3.04. The policies are reviewed and signed on an annual basis and were last updated on August 31, 2016.



The program maintains a permanent bound logbook that records all routine information, emergency situations and incidents pertinent to shelter activities. The agency requires all staff to utilize the log book for the purposes of signing in and signing out as well as documenting shift records of activities, youth counts, staff reviews, and incidents.

A review of the log books for the review period revealed entries document routine daily activities, events, incidents, and address the security and safety of the youth and/or program. All entries are brief and legibly written in ink. Errors are struck through with a single line, initialed, and dated by the staff making the correction. All incoming staff reviews the log book for a minimum of two previous shifts. The shelter manager reviews the logbook every week and documents any corrections, recommendations or required follow-up.

Review of the log book seemed to adhere to the agency's policy. On-coming staff and supervisors consistently indicated that they reviewed the logbook prior to starting their shift. The program director consistently exceeded program requirements and made multiple entries per week including notes.

Navigation of the logbook was difficult at times with no clear methodology for distinguishing various types of information from others.

**Exceptions:**

Corrections to multiple entries were initialed but not dated.

Log entries regarding incidents do not clearly indicate staff involved or provide descriptive information about what took place before, during or after the event.

**3.05 Behavior Management Strategies**

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that meets all required elements listed in the Florida Network Standards for Indicator 3.05. The policies are reviewed and signed on an annual basis and were last updated on August 31, 2016.

The agency's current BMS strives to not only gain compliance with program rules, but to influence the youth to make positive pro-social choices and increase personal accountability and social responsibility. During intake, clients are initially introduced to the BMS and also receive their youth orientation handbook which contains a detailed BMS outline. BMS utilizes a "level system" which allows clients to earn additional privileges such as extra phone calls, later bedtime, outings, and points to spend in the prize cabinet.

Staff participates in annual BMS training and supervisors are specifically trained to monitor the use of behavioral interventions by their staff.

During the tour the Reviewer observed two youth with certificates posted on their walls and one with a small trophy that was recently earned during a "level up".

Interview with two staff during the visit (YCS 2 and YCS 3) indicated they both receive continuing annual training on the BMS.

Three staff files were reviewed while on site and all three contained BMS training certificates.

SPM stated he provides all BMS training himself to new employees and supervisor. Emphasis on proper use of behavioral interventions is reviewed during SPM's monthly meetings held with the staff.

A detailed BMS training outline was provided at time of intake.

No exceptions were noted as of the QI visit.



### 3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that meets all required elements listed in the Florida Network Standards for Indicator 3.06. The policies are reviewed and signed on an annual basis and were last updated on August 31, 2016.

The program has a weekly staffing schedule that is posted. The schedule is based on three shifts: 7am-3pm; 3pm-11pm; and 11pm-7am. Staff is scheduled accordingly to meet the minimum staffing ratios as required by Florida Administrative Code.

Random staff schedules and client census for the past 6 months were reviewed. Staff schedules are completed by both the SPM and YCS 3 to ensure staffing ratios is met. Weekly schedules are posted in SPM's office as well as the staff desk in the common area. The program adheres to a ratio of 1 staff per 6 clients during awake hours and 1 staff per 12 clients during the overnight. Minimum ratios were maintained by ensuring that at least two staff were on duty. The program utilizes part-time staff on a rotating schedule when available to help cover emergency call outs.

Camera video recordings of overnight shifts were reviewed for 11-1-16, 11-10-16, 11-19-16 and 11-21-16. Fifteen minute checks were completed on a consistent basis as documented in the log book.

**Exception:**

Multiple shifts were observed including overnights with only one gender scheduled on duty. SPM indicated that they have recently been experiencing staffing issues and are working diligently to find replacement staff but the problems may continue for the near future.

### 3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

Agency has a very clear and precise policy and procedure to address special population to cover Staff Secure Youth, Domestic Minor Sex Trafficking, Domestic Violence, and Probation Respite. The policy was last reviewed and updated on August 31, 2016.

Upon reviewing the agency's policies and procedures and interviewing with the Executive Director and Shelter Program Manager it is reported that the agency has not served any Domestic Sex Trafficking Youth and due to zoning requirements placed on them. They are not allowed to serve those youth. The agency has not served any Staff Secure Youth since the last review cycle, and has served a total of 10 domestic violence youth within the last six months.

Four domestic violence files were reviewed. All files were neat and organized. All youth had clear documentation of having DV charges pending by having a Face Sheet in every file. Of the four files only one youth stayed longer than 21 days and was transferred over to the CINS/FINS program and this was clearly documented in the file on the Transfer of Services form. All files had Case Plans that reflected goals for anger management and coping skills. The files meet all required general CINS/FINS program Requirements.

No exceptions were noted for this indicator as of this QI visit.

### 3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedures that meets all required elements listed in the Florida Network Standards for Indicator 3.08. The policy was reviewed and signed and was last updated on November 22, 2016.

The shelter utilizes a video surveillance system to promote the safety of all youth, staff, and visitors. The surveillance system is capable of capturing and retaining high resolution video and images including date, time, location, facial recognition and license plates for a minimum of 30 days. Access to the system including offsite remote access is limited only to designated personnel.

SPM demonstrated the system's ability to capture detailed high resolution videos and images for the minimum 30 days as required, and stated that with their new 5 terabyte backup, they are now able to retain the data for even longer.

The shelter operates a 25 camera system throughout the interior and exterior of the facility. Live feed for 16 cameras are visible at both the SPM's desk and staff desk located in the common area and the other 9 cameras are only visible at the SPM's office.

SPM reviews three random shifts weekly and maintains a separate log book indicating time of review, findings and results of findings.

All interior and exterior cameras were clearly visible and a large metal sign was posted at the entrance advising that all activities were under surveillance.

The updated Policy 3.08 contained a list of eight positions/personnel with access (including offsite) to review the surveillance system.

There were no exceptions noted as of the QI visit.

## Standard 4: Mental Health/Health Services

### Overview

#### Rating Narrative

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

Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The Clinical Supervisor and Program Manager are notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented on Alert System Form that is maintained in a binder and is accessible to all staff.

Youth admitted to the shelter with prescribed or over-the-counter medication will surrender those medication to staff during admission. Medications are stored in a Pyxis Med-Station 4000 Medication Cabinet located in the medication room. Over-the-counter (OTC) medications are maintained in another locked cabinet located in the medication room and documented in the OTC medication log. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication ensures that an approved staff is scheduled on each shift. Medication records are maintained for each youth and stored in a MDR Binder.

#### 4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

#### Rating Narrative

The policy for healthcare admission screening contained all the elements required and ensure medical care for youth admitted with chronic conditions and include a thorough referral process for follow-up medical care as needed. The policy requires that the parent/guardian be actively involved in the coordination and scheduling of follow-up medical appointments.

The program has clear procedures to assist staff in determining the youth current medical conditions, illnesses and needs, and the appropriate course of action for admission and emergency medical treatment. The parent/guardian is requested to give approval for or to directly obtain medical treatment for youth in placement.

The review of four active and two closed youth files confirmed that in all the cases the program completed one Healthcare Admission Screening form and one CINS/FINS Intake Form for each youth upon admission and follow-up with the provision of the applicable treatment, notification to parents/guardians, and referrals. The program also calls 911 when youth appears to be in imminent danger of suicide. Staff notifies the Clinical Services Director, the Residential Program Manager, and the Youth Care Specialist III immediately. In practice, the program denied admission if a physician documented serious medical condition of active tuberculosis or MRSA.

There were no exceptions noted for this indicator at the time of the QI visit.

#### 4.02 Suicide Prevention

Satisfactory

Limited

Failed

##### Rating Narrative

The program has a policy related to suicide assessment reviewed on August 24, 2016 and approved, dated and signed by the Executive Director, the Clinical Director, and the Residential Services Manager, to ensure the suicide prevention and response required steps outlined in the Florida Network's Policy and Procedures Manual for CINS/FINS.

The procedures are included in a comprehensive master plan which addresses elements of suicide assessment, precautions and prevention. The suicide risk screening is completed as part of the intake process with additional assessment as warranted. Potentially suicidal youth are placed under constant one-to-one supervision until a clinical assessment of suicide is conducted or the youth is removed from the program. A client safety agreement is completed whenever a safety risk is stated, observed, or indicated and is signed by both the youth and staff.

The assessment of suicide risk is conducted by a licensed mental health professional or a non-licensed mental health clinical staff person working under the supervision of a licensed mental health professional. The plan details notification procedures of the director of program operations and on-call management staff, outside authorities and the parent/guardian. The program's referral system for youth at high risk of suicide includes law enforcement or licensed professionals qualified for off-site mental health services related to suicide prevention/response.

A tour of the program found that the program has a suicide response kit located at the staff station desk, and the National Suicide Prevention Life-Line telephone number posted. The review of four active and two closed youth files indicated that each youth received a suicide risk screening during the initial intake process. Each suicide screening reviewed was signed and dated by the supervisor and documented in the youth case file. Two of the six suicide risk screenings required the completion of the full suicide assessment; however, only one of the two youth was initially placed on sight and sound with observation logs being completed and signed on each shift. The supervision level was not changed until a further assessment was completed by a licensed professional or a non-licensed mental health clinical staff person working under the supervision of a licensed professional. Documentation reviewed found the program has mental health alert protocol for all the four levels of suicide risk.

##### Exception:

In the case of one youth (F.H.) admitted on November 11, 2016 that required (per screening) the completion of the full suicide assessment, the suicide risk assessment was completed next day (November 12, 2016) but there was no any indication the youth was placed on sight and sound observation until the assessment was completed.

#### 4.03 Medications

Satisfactory

Limited

Failed

##### Rating Narrative

The program has a policy related to medications reviewed on August 24, 2016 and approved, dated and signed by the Executive Director, the Clinical Director, and the Residential Services Manager, to ensure the safe and secure storage, access, inventory, disposal, administration, and distribution of medications.

The program has clear procedures for the safe and secure storage of the medications that mandate that all medications, including over-the counter and prescription medications be stored in the Pyxis Med-Station 4000 Medication Cabinet situated in a locked room accessible only to authorized staff members. At the time of the review, the program has six staff members designated as "Super Users" for the Pyxis Med-Station 4000 Medication Cabinet, and a total of eleven staff members that completed the required training and has been authorized by name and title to assist in the distribution of medication when the Registered

Nurse (RN) is not on site. Documentation reviewed found that the RN is on-site part-time five days per week including Saturdays and Sundays, and she distributes medications when she is on site. The program's procedures also require that all staff receive information related to the side effects and precautions on all medication being dispensed.

All medications are stored within the Pyxis Med-station and the Med-station is stored in a locked medical office which is inaccessible to youth. Oral medications are stored separately from both injectable and topical medications within the Pyxis Med-station. The program maintains a secured refrigerator which is used only for the storage of medication. When on duty, the nurse conducts medication pass. Controlled substances are perpetually inventoried by the electric Pyxis Med-station. A perpetual inventory is maintained for OTC medication via a hand-written log and in the Pyxis Med-station. Individual Medication Distribution Log forms are maintained to document distribution of OTC medication by all staff to each youth.

Syringes and sharps are secured and documentation of weekly inventory is maintained. There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports. Overall, the delivery of medication is consistent with the FNYFS Medication and Distribution Policy.

No exceptions were noted for this indicator at the time of the QI visit.

#### 4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

##### Rating Narrative

The program has a policy related to medical/mental health alert process reviewed on August 24, 2016 and approved, dated and signed by the Executive Director, the Clinical Director, and the Residential Services Manager, to ensure the information concerning a youth's medical condition and other pertinent treatment information is effectively communicated to all the program's staff.

The program has procedures for the development, implementation, and practice of a medical and mental health alert system to timely communicate any youth's health related condition to all the staff in the program, and to the parents/guardians to determine the best course of action and make the necessary arrangements for the youth's medical needs to be addressed. Communication of the alerts included preliminary screening information, staff logbooks, Medication Distribution Logs (MDLs), case notes, and youth's files.

A tour of the program, staff interviews and the review of the youth's files confirmed that the program has a color code alert system that includes a medical and mental health clipboard located in the supervisor's office, and a Food Special Diets board located in the kitchen. In addition, each youth file reviewed has a color code alert label located in the cover of the file, when applicable. Some staff had the program's color code in their cellular phones. Staff interviewed indicated that they read the alert system log daily before starting a shift. The Alert Codes Reference Chart was observed posted throughout the program.

The review of six youth files confirmed that youth was appropriately placed on the alert system when they have any medical and mental health condition or food allergy. The program's alert system includes precautions concerning prescribed medications, and medical or mental health conditions. Staff interviewed indicated that they received sufficient information and instructions to recognize and respond to the needs for medical or mental health services. The program's medication binder and the Medication Distributions Logs (MDLs) were reviewed to confirm practice.

There were no exceptions noted as of the QI visit.

#### 4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

**The program has a policy related to episodic/emergency care reviewed on September 21, 2015 and approved, dated and signed by the Executive Director, the Clinical Director, and the Residential Services Manager to ensure the provision of emergency medical and dental care that contained all the mandatory components.**

**The program requires that all staff complete training and are certified in first aid and cardiopulmonary resuscitation (CPR), the use of the Knife-for-Life, and emergency procedures. The program's procedures also require that staff be prepared to address any environmental stressors for the day, and any episodic/emergency care administered to youth be documented in the youth's files, and the alert system, when applicable, with outcomes and resolution.**

**Staff interviewed indicated that they knew how to obtain off-site emergency services, notify the youth's parents/guardians when needed, call the Central Communication Center (CCC), implement the daily log, and the procedures to follow upon youth return to the shelter from emergency care. The program had one incident during the review period that contained parental notification. The incident was documented in the Episodic Emergency Care log. Documentation reviewed confirmed that the program consistently conducted emergency drills with different medical emergency scenarios each time.**

**There were no exceptions noted as of this QI visit.**