



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of LSF SW- Oasis

on 01/25/2017

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	Limited
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Limited
1.07 Outreach Services	Satisfactory

Percent of indicators rated Satisfactory: 71.43%
 Percent of indicators rated Limited: 28.57%
 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	Limited
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: 87.50%
 Percent of indicators rated Limited: 12.50%
 Percent of indicators rated Failed: 0.00%

Standard 2: Intervention and Case Management

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

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	Limited
4.03 Medications	Satisfactory
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

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

Percent of indicators rated Satisfactory: 85.19%
 Percent of indicators rated Limited: 14.81%
 Percent of indicators rated Failed: 0.00%

Rating Definitions

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

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

Review Team

Members

Keith Carr, Lead Reviewer, Forefront LLC/FNYFS

Nickie Hartsock, Residential Supervisor, Family Resources

Keith Bennis, Regional Monitor, Department of Juvenile Justice

Teresa Clove, Executive Director, Thaise Educational and Exposure Tours

Shad Renick, Residential Director, Sarasota YMCA

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 type="checkbox"/> Program Director | <input checked="" type="checkbox"/> Program Manager |
| <input type="checkbox"/> Program Coordinator | <input checked="" type="checkbox"/> Direct- Care Full time | <input 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 checked="" type="checkbox"/> Nurse | | |
| 2 Case Managers | 0 Maintenance Personnel | 1 Clinical Staff |
| 0 Program Supervisors | 1 Food Service Personnel | 0 Other |
| 0 Health Care Staff | | |

Documents Reviewed

- | | | |
|---|--|--|
| <input checked="" type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input checked="" type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input checked="" type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Fire Drill Log | 7 # Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 7 # MH/SA Records |
| <input checked="" type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 20 # Personnel Records |
| <input checked="" type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 12 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 12 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input checked="" type="checkbox"/> Telephone Logs | 7 # Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

5 Youth 7 Direct Care Staff

Observations During Review

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

Comments

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

Rating Narrative

No Status Offender files were available for review over the last year.

Strengths and Innovative Approaches

Rating Narrative

Lutheran Services Florida - Oasis Youth Shelter located in Fort Myers, Florida provides the Children in Need of Services/Families in Need of Services (CINS/FINS) program. Lutheran Services Florida (LSF) is the designated CINS/FINS provider for Lee, Charlotte, Collier, Hendry, and Glades Counties.

The Oasis Youth Shelter provides non-residential and short-term residential services for youth ages ten to seventeen, that do not have any current open cases of delinquency or dependency. Nine of the residential beds are allocated to the Department of Juvenile Justice (DJJ). In addition, the shelter provides services to youth from the Department of Children and Families (DCF)- thirteen beds are allocated for them. The program also provides a comprehensive continuum of non-residential services to these youth and families.

There were many changes to the Oasis shelter since the last QI visit. They are as follows:

- The LSF SW regional administrative office was recently remodeled. The office has been improved with new flooring, paint and repairs.
- They have partnered with Children's Advocacy Center of Southwest Florida (CAC).
- LSF SW implemented "pet therapy" as part of their group counseling services. Certified trainers from the area come to the shelter with their canines and work with the youth approximately twice per month. The program is really a huge success and the youth interact and respond to the animals with positive reinforcement techniques (along with a lot of hugging and petting).
- They hired a Child Welfare Case Manager. She is currently working on being certified. This CM works solely with the CMO youth at Oasis. She works in partnership with the CMO case manager, placement specialists, and other involved parties like the GAL. The intent of this position is to assist the CM and placement staff with identifying and transitioning the youth to appropriate placements in a timely manner as well as assisting the youth in accessing additional services/resources needed while they reside at the shelter. The CM has become part of the Oasis team and is housed there as well. Although this process is challenging, the CM has assisted the CMO youth in many ways including acting as a liaison between the youth and primary CWCM and expediting a youth's access to needed services/resources. There is much more potential to be had with this position as the needs of a CMO youth are more intensive; however this position is warranted and will absolutely continue to benefit CMO youth.
- The shelter manager has been working on a mentoring program in house by linking/matching a staff member up to a youth when they first come in.
- The shelter manager is now certified to teach Managing Aggressive Behavior which will be valuable in ensuring training is conducted with all shelter staff in a timely manner which in turn will be beneficial for youth served in the program.
- They have entered into an agreement with Applied Technologies to implement the NoteActive Digital log book. They anticipate going live in the beginning of February and will slowly begin implementing all phases of what the NoteActive software is capable of. They believe it will greatly improve the communication and overall program accountability at Oasis.

Standard 1: Management Accountability

Overview

Narrative

The program management team is comprised of a Vice President of Programs located in Tampa Florida; Executive Program Director located in Fort Myers; a Clinical Director (LCSW) who supervises Prevention/Intervention, Quality Assurance, and Residential and Non-Residential Counseling programs; a Residential Services Manager; a Youth Care Supervisor (YCS III); a Shelter Case Manager; a Part time Registered Nurse, and a Senior Administrative Assistant.

The program provides first year training, as well as annual training, to ensure that all staff are properly trained for the jobs they perform. The program staff, the Florida Network, the Fort Myers Fire Department, the Red Cross, and other outside agencies provide training.

The program has numerous inter-agency agreements that are used to network with the surrounding communities, such as low-performing schools, community parks, and various designated neighborhoods in an effort to make agencies, youth, and families aware that services are available to address the needs of youth at risk and their families.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedures (1.01) addressing background screening of employees and volunteers, which was last revised and approved on August 24, 2016 by the program's Executive Director, Clinical Director, and Shelter Manager. 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. The Annual Affidavit of Compliance with Good Moral Character Standards (form IG/BSU-006) must be completed by the program and sent to the DJJ Background Screening Unit by January 31st of each year.

According to the program's written procedures, any potential new hire must have a background screening conducted prior to the hiring of an employee or volunteer. This is conducted using The Department of Juvenile Justice's (DJJ) Background Screening Unit (BSU) Live Scan. In addition to the DJJ Background Screening, the provider also conducts a driver's license screening for new hires and then annual driver's license screening thereafter. The agency will update the Affidavit of Compliance with Good Moral Character Standards annually and provide appropriate documentation that accompanies this form by January 31st of each year.

A total of eighteen personnel files were reviewed for twelve new hires, one five-year re-screened staff, and five interns. Eleven of the twelve new hires were screened and received an eligible screening result prior to their hire dates. One of the new hires had a hire date of 05/23/16 and a background screening was submitted to DJJ's BSU on 05/13/16; however, the background screening was not completed by the BSU until 06/01/16 and the staff started on 05/23/16.

The five interns utilized by the provider during the review period were background screened and eligible screening results were obtained prior to their start dates. The provider had one eligible five-year re-screening due during the review period. The 5-year re-screenings was submitted to DJJ's BSU and the result was obtained prior to the employees' five-year anniversary date. Reviewed documentation reflected the Annual Affidavit of Compliance with Good Moral Character Standards was received by DJJ's BSU on January 19, 2017 (prior to the January 31st requirement).

Exception:

One of the program's new hires had a hire date of 05/23/16 and a background screening was submitted to

the Department's Background Screening Unit (BSU) on 05/13/16; however, the background screening was not completed/cleared by the BSU until 06/01/16 and the staff started on 05/23/16.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedures (1.02) addressing the provision of an abuse free environment, which was last revised and approved on August 24, 2016 by the program's Executive Director, Clinical Director, and Shelter Manager. The policy reflects the program's staff code of conduct, dress code expectations, behavior expectation guidelines, grievance procedures, and responsibility/protocol for reporting child abuse are clearly outlined in the program's policy and procedures. Additionally, the policy includes procedures for ensuring a code of conduct for staff; the reporting of all allegations/suspected abuse to the Florida Abuse Hotline; having an accessible/responsive grievance process for youth to provide feedback/address complaints; and requiring management to take immediate actions to address incidents of physical and/or psychological abuse, verbal intimidation, use of profanity, and/or excessive use of force.

During orientation training, staff review the agency's Personnel Policies and Procedures Manual and sign an acknowledgement of receipt form. A copy of this acknowledgement form is maintained in each employee's personnel file. Additionally, child abuse reporting training is included in staff orientation. New staff also sign a Staff/Volunteer Code of Conduct form reflecting their agreement with the program's rules. Staff sign an acknowledgement form stating they have read the staff behavioral expectations and agree to them.

The policy and procedure also covers the grievance procedure for staff outlining how youth may acquire a written grievance form from staff, which is also located in their orientation packet. The manager or their designee will review the grievance within 24 hours, when possible, and within 72 hours in all cases. The grievance will be addressed and an attempt to resolve the situation will be made by the program's administrator assigned to handle the grievance. If a satisfactory resolution is not agreed upon by both parties, the youth may request the grievance be forwarded to the agency's local Executive Director who will review the case and contact the parties involved within 72 hours and make a second attempt at resolving the situation to the satisfaction of both parties. If this does not bring a satisfactory resolution to both parties, the youth may request the grievance be forwarded to the agency's Vice President for further attention and a final attempt at resolving the situation.

The Florida Abuse Hotline telephone number was visibly posted throughout the shelter and is also listed in the Resident Orientation Handbook. The Resident Orientation Handbook is reviewed with each youth and their parent/guardian during admission. The youth and parent/guardian sign the orientation checklist acknowledging receipt of the handbook and their understanding of the information provided during orientation.

Observations made during the review reflected staff were abiding by the staff dress code expectation. A review of twenty-five employee files was conducted and each contained a signed acknowledgement form reflecting they have reviewed the program's Personnel Policies and Procedures Manual. During the review period, there were a total of six client grievances filed. Reviewed documentation reflected the program followed the procedures listed in their policy for each. Furthermore, during this review period, none of the direct care staff were written up or disciplined for any incident abuse, neglect, and/or excessive use of force.

No exceptions were noted for this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedures (1.03) addressing incident reporting, which was last revised and approved on August 24, 2016 by the program's Executive Director, Clinical Director, and Shelter Manager. The policy reflects procedures for the notification of reportable incidents to the Department of Juvenile Justice's Central Communication Center (CCC) within two hours of the incident or within two hours of becoming aware of the incident. The program also completes follow-up communication tasks/special instructions required by the CCC in order to close the case and assure the incident has been fully attended to as needed.

Incident Report training is included in the provider's training plan for new staff to complete during staff orientation. Staff receive training on this topic from the Clinical Manager and/or the Shelter Manager. The program's Executive Director and the Clinical and Residential Services Management Team will review all serious and severe incidents immediately and will respond accordingly, thus ensuring the safety and well-being of both the youth and the staff. The procedures require all incident reports to be faxed daily to the program's Executive Director for review.

Staff responding to serious incidents are to immediately consult with their supervisor about the incident. If the type of incident is on the Department's reportable incident list, staff are to call the Central Communications Center (CCC) within two hours, notify the Clinical Manager and/or Shelter Manager immediately after calling the CCC, and then enter the incident in the log book. In the case of unusual incidents or alleged abuse, staff shall immediately notify the Clinical Manager and/or Shelter Manager during daytime hours and the Clinical or designee during evening/night and weekend hours.

Unusual occurrences include, but are not limited to medication errors, injury or the possibility of injury, verbal and/or physical altercations, allegations of abuse or neglect by staff, runaway activity, and/or suicide attempts. Incidents are documented on an agency incident reporting form which 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. The program's practice is to attach an Incident Reporting Cover Sheet, which summarizes the incident, to each residential Incident Report Form and email/fax this to the agency's Statewide Director of QA and Compliance. Additionally, the practice reflects both the Clinical Manager and the Shelter Manager review all incident reports on a twenty-four-hour basis and all Level I incidents require a summary of staff debriefing.

A review of twenty-five personnel files reflected each staff member signed a policy acknowledgement form reflecting they are aware of the program's mandatory child/adult abuse, neglect, abandonment, or exploitation reporting requirements. A review of twelve staff training files reflected each staff received incident report training.

During the review period, the program had a total of nine incident reports for non-residential and a total of eighty-three incident reports for residential; five of which were reported to the Central Communications Center (CCC) and were accepted. There was no clear record of program staff faxing incident reports to the program's Executive Director for review; however, an interview was conducted with the Executive Director and she stated she reviews all incidents on a daily basis. A review of all incident reports reflected fifteen were reviewed by the Clinical Manager or Shelter Manager beyond twenty-four hours and three had no evidence that they were reviewed at all.

Furthermore, there was a total of eight Level I incidents which did not have a summary of staff debriefing (07/03/16, 09/25/16, 10/10/16, 10/17/16, 11/03/16, 11/30/16, 12/12/16, 12/27/16). There was evidence that the Clinical Manager and Shelter Manager keep a log and track the number and severity of incidents on a bi-weekly basis. Each of the incident reports were documented on incident reporting forms.

During this review period, the program had a total of fourteen Level I incidents which required a staff debriefing. Six of the fourteen Level I incidents had a completed staff debriefing after the incident, as required, and eight did not (07/03/16, 09/25/16, 10/10/16, 10/17/16, 11/03/16, 11/30/16, 12/12/16, and 12/27/16). Reviewed documentation of the five incidents reported to the CCC reflected one was related to a client that

was missing, one for a motor vehicle accident without injury, one for contraband, one for medication error, and one for abuse/neglect.

A review of the program's logbooks reflected three of these five CCC incidents were documented in the logbook as required and two were not. Each of the five reported incidents were reported within the required two-hour time frame. Reviewed documentation of the seventy-eight internal residential incident reports not called into the CCC reflected two should have been called into the CCC due to the nature of the incident. These included an incident on 08/04/16 (BA 52 – Baker Act / self harm) and on 11/07/16 (contraband).

Exceptions:

Six of the fourteen Level I incidents reviewed had a completed staff debriefing after the incident as required; however, eight did not (07/03/16, 09/25/16, 10/10/16, 10/17/16, 11/03/16, 11/30/16, 12/12/16, and 12/27/16).

Reviewed documentation reflected the program had five serious incidents which were called into the CCC as required. A review of the program's logbooks reflected three of the five CCC incidents were documented in the logbook as required and two were not (09/02/16 & 01/13/17).

Reviewed documentation of seventy-eight internal residential incident reports not called into the CCC reflected two should have been called into the CCC due to the nature of the incident. These included an incident on 08/04/16 (BA 52 – Baker Act / self harm) and on 11/07/16 (contraband).

There was no clear record of program staff faxing incident reports to the program's Executive Director for review; however, an interview was conducted with the Executive Director and she acknowledged this and confirmed all incidents are reviewed by her as they occur.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The shelter policy for training requirements is identical to the Training Requirements indicator. This policy was last reviewed and signed by the Executive Director and Shelter Manager on August 24, 2016.

The program has a procedure in place that reflects what is required in the Florida Network standard. Training is required by all staff and monitored by the Shelter Manager and the Clinical Director. The program has an annual training plan in place. Staff are provided agency and job specific orientation. Job shadowing is required.

The program's annual training plan was reviewed and it is being utilized by staff. The program maintains individual training files for each staff, which includes a training tracking form, and certificates or sign-in sheets.

Two of the files reviewed were Non-Licensed Mental Health Clinical staff and both training files had documentation of training by a Licensed Clinician in Assessment of Suicide Risk.

Two Non Residential Counselor training files were reviewed and both are on track to complete their required training hours and required training topics.

Ten shelter files were reviewed. Six of the ten training files reviewed the staff are currently in their first year of hire. All are on track to complete the required 80 training hours and trainings. Three staff have been with the agency for more than one year and are on track to complete the required training hours.

One staff has been employed since June and has not completed CPR/First Aid or medication training.

Exception:

There is a lack of consistency in the training documents in that there are missing initials of either the trainer or the trainee. In one file reviewed, the form used to document proof of shadowing was blank and only signed by the staff person. This form was not signed by the supervisor or staff member, the hours were not totaled and the topics covered were not specified. Between the training records and new employee forms there needs to be more consistency with dates being entered and initials.

One staff whose employment started 7/26/16 did not complete four of the trainings that are required to be completed within 120 days of hire.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program's analyzing and reporting information policy is identical to the Analyzing and Reporting Information indicator. The policy was last reviewed and signed on August 24, 2016 by the Executive Director, Clinical Director, and the Shelter Manager.

During the analyzing process, any findings are reviewed by management and shared with staff. All parties are involved in making changes to address any issues or trends.

The program completes monthly peer reviews for the shelter and non-residential program. Two binders were reviewed that contained documentation of the peer reviews being completed.

A review of the CQI monthly spreadsheet and staff meeting agenda indicate monthly review/discussion of incidents, accidents, and grievances; customer satisfaction data; outcome data and Netmis data. Minutes indicate discussions including all staff gathering ideas and feedback to make improvements with issues or trends that have come up in the shelter or non-residential program.

The comparison report shows the program's plan for addressing any issues or trends found and who will be responsible for following through to make sure changes are made.

Also, the nurse is accessing the Pyxis reports to monitor users and discrepancies. She provided a current discrepancy report for the review.

There were no exceptions noted for this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedures (1.06) addressing client transportation, which was last revised and approved on August 24, 2016 by the program's Executive Director, Clinical Director, and Shelter Manager. The procedure of the policy 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.

The agency has procedures outlining several aspects of client transportation. It states staff must ensure they are never in a one-on-one situation with any youth while transporting. When another Youth Care Staff is unavailable to assist with transportation, the youth care staff may utilize interns, volunteers, or may utilize other youth during transport. Only in extreme cases are staff permitted to transport youth one-on-one; however, they must receive permission from the Shelter Manager to do so. This approval must be documented in the van log by the van driver.

A list of authorized drivers will be kept by the program's Senior Administrative Assistant. All staff must make themselves aware of behavior management alert code information and plans for the clients for who they are providing transport. Each vehicle owned or leased by the program will have a van logbook. Each book will record the name and signature of the driver, where they are traveling to, and the odometer readings traveled. The log book must be completed for each trip the van makes even if clients are not present.

The agency will develop and implement procedures for the annual inspection of all vehicles used to transport youth. Vehicles will be inspected on a weekly basis by the designated YCS III and all issues/problems will be reported to management as soon as they are observed. All vehicles used to transport youth shall be equipped with first aid kits, a fire extinguisher, seat belts, a seat belt cutter, and a window punch. The program will maintain adequate supplies and place orders as needed and on a regular basis.

Reviewed documentation reflected the program has a clear and valid certificate of liability insurance through Bouchard Insurance which expires on 06/01/17. This is an umbrella policy which covers employees who are transporting youth during their normal assigned duties. The program's Senior Administrative Assistant maintains a list of approved agency drivers which was also maintained in the Department of Juvenile Justice's Staff Verification System. The agency conducts driver's license checks/screenings annually.

A review of two vehicle transportation logs was conducted for a charcoal gray Honda van and a white Ford van. Each log included the date, number of staff, driver or staff name, number of youth, activity and location, time out and time in, mileage start/end, and cleanliness/maintenance comments (if applicable). Each of the two vans were observed by this reviewer and each were equipped with first aid kits, a fire extinguisher, seat belts, a seat belt cutter, and a window punch.

Reviewed documentation reflected the vans were last inspected by certified mechanics on 12/20/16 for the Ford van and on 04/01/16 for the Honda van. Reviewed documentation reflected the program conducts weekly inspections on each of the vehicles. Any issues/problems discovered are to be reported to management as soon as they are observed. Reviewed documentation of vehicle logs reflected the program does not have a specific YCS III identified to complete this on a weekly basis and this practice was not being completed on a consistent basis. Often times, there was documentation of the vehicles being inspected each time they were used; however, there were large gaps where they were not inspected on a weekly basis. The program continues to utilize Zee Medical Services Co. since 2010 to maintain adequate supplies and place orders as needed and on a regular basis.

According to guidelines in Indicator 1.06, if a driver is transporting a single youth in a vehicle, there must be evidence of a supervisor being aware prior to the transportation and consent is to be documented accordingly on the vehicle log. A review of the logbooks reflected there was a total of seventeen instances of one-on-one transportation with a single staff member and a single youth. Seven of the seventeen instances had evidence of the Shelter Manager's approval on the log; however, ten did not (07/16/16, 07/18/16, 07/19/16, 10/11/16, two instances on 12/15/16, 12/16/16, 12/21/16, 01/09/17, and 01/13/17).

Exception:

A review of the two vehicle logbooks reflected there was a total of seventeen instances of one-on-one

transportation with a single staff member and a single youth. Seven of the seventeen instances had evidence of the Shelter Manager's approval on the log; however, ten did not (07/16/16, 07/18/16, 07/19/16, 10/11/16, two instances on 12/15/16, 12/16/16, 12/21/16, 01/09/17, and 01/13/17).

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The program policy is identical to the Outreach Services indicator. The policy was last reviewed and signed on August 24, 2016 by the Executive Director, Clinical Manager, and Shelter Manager.

The program provides presentations in the community and distributes written information about their services. These written documents include annual reports, brochures, and posters.

The program maintains a binder containing agendas from various community meetings and attendance at DJJ Advisory Board Meetings. Handwritten on the agendas are notes taken are the names of the staff who attended.

The Shelter Program Manager and Executive Director regularly attend the DJJ Advisory Board meetings.

There are numerous outreach presentations completed monthly in the community. A form is kept in the binder and indicates who gave the presentation, location, and clientele the presentation is made to.

The program maintains inter-agency agreements with various agencies in the area. Review of the inter-agency agreement binder indicates up-to-date agreements with Lutheran Services and various agencies. Most of the agreements have no expiration date.

There were no exceptions noted for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The Oasis Youth Shelter provides an array of prevention services through a residential and non-residential program for youth their families who display risk factors such as truancy, ungovernability, runaway behavior, domestic violence, substance abuse, and family conflict. Referrals may come from the youth themselves, parents/guardians, schools, law enforcement, or other community entities.

The residential program provides centralized intake and screening twenty-four hours per day, seven days per week. Trained staff are available to determine the needs of the family and youth. The youth and family participate in a screening and intake process in order to ascertain eligibility and develop an individualized plan of services meeting their needs. Residential counseling services including individual, family, and group therapy. Case management and substance abuse prevention services are also offered. Referral and aftercare services begin when the youth are admitted for services. Aftercare planning includes referring youth to community resources, ongoing counseling, peer support, advocacy, financial assistance, housing assistance, and educational assistance.

Lutheran Services Florida coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee meets at a minimum six times monthly and can also recommend a CINS Petition be filed to court-order participation with treatment services.

The Non-Residential program is under the direct supervision of a Clinical Director who supervises the clinical team comprised of 6 Counselors (1 Lead Counselor, 1 Counselor II, and 5 Counselor I). The Non-Residential program is divided into two components: clinical and prevention/intervention.

Prevention/Intervention is comprised of 4 Counselor I positions. Services provided include individual, family and group counseling along with case management services. Case management services include life skills, social skills and referrals for services upon the youth's return to the home. Youth also receive referrals for substance abuse and mental health services.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

Lutheran Services has a written policy that addresses all the requirements for the Screening and Intake indicator. The policy was reviewed and last updated on August 24, 2016 and signed by the Executive Director, Clinical Director and Residential Services Manager.

The procedures for screening and intake are as follows: The initial screening is to be received by phone or face-to-face by a trained staff. Information is to be gathered to determine if the youth is eligible for CINS/FINS services within 7 days. Once the youth is deemed eligible for service, the Non-Residential and Residential staff is to be assigned to the youth and schedule an intake session with the client and his/her guardian. Both will initiate the Needs Assessment within 72 hours of completing the Intake Assessment. The Non- Residential Services will complete the Needs Assessment within 2 to 3 sessions or visits and the Residential Services will complete the Needs Assessment within 7 days of completing the Intake Session.

A total of eight (8) files were reviewed, four (4) Non-Residential (3 closed and 1 open) and four (4) Residential (3 closed and 1 open).

Lutheran Services Central Intake office is held in the Non-Residential building and is available 8:30 to 5 pm for Non-Residential and Residential youth. All Residential screenings are received at the Shelter seven days a week. All screenings were received and were screened for eligibility within the seven (7) day standard, in fact all the screenings were deemed eligible within 1 to 3 days of the referral and was assigned

a counselor within that time-frame. The intake Assessment and Needs Assessment were completed within the same day of Intake and/or within the time-frame allotted.

During the Intake session, the parent and the client received in writing the available service options, the right and responsibilities, the grievance procedure, the agency Handbook and the possible actions that could occur during involvement with CINS/FINS services.

There were no exceptions noted for this indicator.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

Lutheran Services has a written policy that addresses all the requirements for the Needs Assessment indicator. The policy was reviewed and last updated on August 24, 2016 and signed by the Executive Director, Clinical Director and Residential Shelter Manager.

The agency's procedures are clearly identified. For the shelter, a Bachelor's level staff is to complete a written Needs Assessment within 72 hours of admission. For Non-Residential Services, a Bachelor's level staff is to initiate and complete the Needs Assessment within two (2) to three (3) face to face contacts following the initial Intake. A supervisor must review and sign the Needs Assessment upon completion for both Non-Residential and Residential Services. If a youth is identified as having a suicide risk behavior during the Needs Assessment, the youth is referred for an Assessment of Suicide Risk conducted by or under the direct supervision of a Licensed Mental Health Professional.

A total of eight (8) files were reviewed, four (4) Non-Residential (3 closed and 1 open) and four (4) Residential (3 closed and 1 open).

The Needs Assessment for four (4) Non-Residential and three (3) Residential youth were implemented and completed on the same day of Intake by a Bachelor level staff and were signed and reviewed by the supervisor. One (1) Residential file did not complete the Needs Assessment because the parent came in and discharge the youth the same day on Intake.

Two Non-Residential youth were identified as having suicide risk behaviors and was given an Evaluation of Suicide Risk Among Adolescents. One (1) Evaluation of Suicide Risk Among Adolescents was reviewed and signed by a license clinician and one (1) was not.

Exception:

Two Non-Residential youth were identified as having suicide risk behaviors and was given an Evaluation of Suicide Risk Among Adolescents. One (1) Evaluation of Suicide Risk Among Adolescents was reviewed and signed by a license clinician and one (1) was not.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

Lutheran Services has a written policy that addresses all the requirements for the Case/Service Plans indicator. The policy was reviewed and last updated on August 24, 2016 and signed by the Executive Director and Clinical Director.

The procedures note that after a case is opened, a Case/Service plan is to be developed within seven (7)

working days following the assessment. It should identify the services that will be rendered to the client/family to assist them in reaching their goal.

A total of eight (8) files were reviewed, four (4) Non-Residential (3 closed and 1 open) and four (4) Residential (3 closed and 1 open).

The Case/Service Plans were developed on the same date as the Needs Assessments in all four (4) of the Non-Residential case files and two (2) of the Residential files, which means they were done on the same day of intake. Two (2) were not completed in the Residential case files due to being discharged on the same day they were admitted.

The Case/Service Plans all addressed the following areas:

- Identified Needs and goals,
- Type, frequency, and location,
- Target dates,

- Actual completion dates,
- Date plan was initiated and
- Signatures of the youth, parent, counselor and supervisor.

This reviewer was not able to confirm that the Non-Residential Case/Service Plans were being reviewed with the parent and the client on a consistent basis either by phone or in person. After reviewing four (4) Non-Residential case files, it appears that the counselors are only trying to reach the guardian by phone to do the Case/Service Plan Reviews. The viewer could not determine whether the agency's practice is to meet with the youth and parent face to face or to speak with the family by phone. There were no Case/Service Plan reviews initiated for the four (4) Residential files due to being discharged before a review was needed.

For one (1) Case/Service Plan, reviews were never completed with the client and the guardian although a phone call attempt was made to the mother once for each 30, 60, and 90 Day reviews. The counselor was not able to contact the client or guardian on that specific day, but stated in the progress notes that the reviews were completed.

The second youth file, a 30-Day Review was completed by phone with the mother only. The youth was not available. The 60-Day Review was completed in person by the youth/parent and was signed. The 90-Day Review was not completed with the parent or the youth. The counselor made one attempt by phone to reach the youth and the guardian but was not able to make contact. The counselor was unable to leave a message due to no voice mail capability, but stated in the progress notes that the review was completed and the case was closed.

The third youth file, a 30-Day Review was completed by phone with the mother only. The youth was not available. The previous day the counselor met with the youth but did not complete the 30-Day Review but scheduled it the following day. The following day the youth was not available, therefore a review was not completed with the youth. The 60-Day Review the counselor spoke with youth's mother by phone but the youth was not available. The 90-Day Review was completed by phone with youth's mother. The youth was not available.

The fourth youth file, one phone call was made to the youth's mother for the 30-Day and for the 60-Day

Review but was unavailable. The youth was unavailable for the 30-Day Review but was available for the 60 Day Review. The counselor stated in her progress notes that she had completed the review even if she had not spoken to the youth or the mother. The 90-Day Review was completed with the youth in person but with the mother by phone.

There were no exceptions noted for this indicator.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

Lutheran Services has a written policy that addresses all the requirements for the Case Management and Service Delivery indicator. The policy was reviewed and last updated on August 24, 2016 and signed by the Executive Director, Clinical Director and Residential Services Manager.

The agency require that each youth is assigned a counselor and is provided an array of services that utilizes appropriate resources for children and their families.

A total of eight (8) files were reviewed, four (4) Non-Residential (3 closed and 1 open) and four (4) Residential (3 closed and 1 open).

Six (6) out of the eight (8) case files were assigned a counselor and were offered services. Two of the Residential case files were not assigned a counselor and did not receive services due to being discharged the same day and due to running away on the same day of intake. Recommendations were made to the parent of the youth who was discharged the day of intake. In each of the six case files, the youth and family were provided the required services as stated in this indicator.

There were no exceptions noted for this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

Lutheran Services has a written policy that addresses all the requirements for the Counseling Services indicator. The policy was reviewed and last updated on August 24, 2016 and signed by the Executive Director, Clinical Director and Residential Services Manager.

The program's procedures address how the youth can access services, whether the youth needs respite services as a cooling off period, who are being identified for services, who provides the services and that the Non-Residential and Residential Services will be subjected to a quality assurance review.

A total of eight (8) files were reviewed, four (4) Non-Residential (3 closed and 1 open) and four (4) Residential (3 closed and 1 open).

All Non- Residential and Residential services provided counseling for the youth and for the families. Their presenting problems were addressed in their service plans and their progress was documented in their individual case files. The supervisor reviewed the files monthly and documented the review by signing a

case note in the files. The Residential Services offered group counseling for the youth in shelter. Two (2) out of the four (4) youth participated in the group and individual counseling. The other two (2) were discharged before they could participate in the sessions. The discharge plans were completed and recommendations were made for those two youths.

There were no exceptions noted for this indicator.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

Lutheran Services has a written policy that addresses all the requirements for the Adjudication/Petition Process indicator. The policy was reviewed and last updated on August 24, 2016 and signed by the Executive Director, Clinical Director and Residential Services Manager.

Lutheran Family Services has developed a case staffing committee (also labeled as TURN) that is committed to ungovernable, runaway and truant youth. The case staffing team meets every other week in Lee County and consist of a host of representatives from DJJ, schools, the state attorney, CINS/FINS representative, and more.

A total of eight (8) files were reviewed, four (4) Non-Residential (3 closed and 1 open) and four (4) Residential (3 closed and 1 open).

Only one (1) Non-Residential youth was chosen to go through case staffing. The case followed the protocol for scheduling a case staffing. The counselor initiated the staffing and sent a letter notifying the parent of the case staffing. The letter was sent out in the appropriate time-frame (more than 7 days before the staffing). As a result of the case staffing, a new Case/Service Plan was implemented and signed by the client and the parent.

There were no exceptions noted for this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

Lutheran Services has a written policy that addresses all the requirements for the Youth Records indicator. The policy was reviewed and last updated on August 24, 2016 and signed by the Executive Director, Clinical Director and Residential Services Manager.

The agency has developed a procedure that assures a case record is maintained for each youth enrolled in the program and that the case files are marked confidential and kept in a secure, locked location.

A total of eight (8) files were reviewed, four (4) Non-Residential (3 closed and 1 open) and four (4) Residential (3 closed and 1 open).

All eight (8) files were marked confidential and are kept in a secure, locked file cabinet and in a locked room. The file cabinets are also marked confidential.

The records are transported in a large, black digital lock rolling case and a small black hand held digital lock carrying case. Both were marked confidential.

All youth records/files were neat and orderly. The open files were in a note book binder and the closed cases were in a paper binder.

There were no exceptions noted for this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The Oasis Youth Shelter is a twenty-two bed residential shelter that is licensed by the Department of Children and Families (DCF) and operated by Lutheran Services Southwest. The facility is also licensed to provide children's substance abuse services for Prevention Level 1 and Outpatient Treatment.

This shelter is designated by the Florida Network to provide staff secure services, Domestic Violence (DV) respite, Probation Respite, and Domestic Minor Sex Trafficking. The program had not served youth meeting the criteria for the latter three services during the review program.

LSF-SW Oasis shelter building includes a large day room, 6 x girls' and boys' sleeping rooms, kitchen, laundry, staff offices and a secured internal courtyard area. The furnishings are in adequate condition and the rooms and common areas were clean. The dormitory is divided into two separate areas, one for the boys and one for the girls. There are 2 bathrooms, one for each gender; the female bathroom was currently under reconstruction at time of site review visit. The bathrooms floors are tiled and the plumbing appeared functional. The sleeping rooms houses about four (4) youth each. The sleeping room is equipped with two metal bunk beds and each youth has an individual bed, bed coverings and pillows. The windows are fitted with blinds for privacy for the youth. In addition, the youth have access to a recreational games, volley ball court, and basketball.

The Shelter staff consists of a Residential Program Manager, a Clinical Manager, a Youth Care Specialist Supervisor, a Youth Care Specialist Shift Supervisors, Youth Care Specialists, Counselors and a Case Manager. The Shelter runs three shifts per day. The provide individual, group and family counseling services for CINS/FINS youth as well as youth involved with DCF and the Foster Care System. The Shelter has been renovated within the last year. The average length of stay for youth is 18 days.

The Direct Care workers are responsible for completing all applicable admission paperwork conducting youth orientation to the shelter, and providing necessary supervision. Staff maintains inventories on all sharps and medications, provides distribution of prescribed and over-the-counter medications, administers first aid when needed, and coordinates all offsite appointments to medical providers. First aid kits are located in several locations throughout the facility to include the medication office and kitchen. All medications are stored in the Pyxis MedStation.

Oversight of clinical services is provided by Clinical Manager. The program has policies and procedures in place for its Shelter Care programming. The Shelter Environment, Program Orientation, Youth Room Assignment, Log Books, and Behavior Management Strategies policy and procedure are all adequately written and more recently updated to reflect the Florida Network's standards.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedures that addresses all the requirements for the Shelter Environment indicator.

Health and fire safety inspections are to be conducted annually. The Shelter furnishings are kept in good repair. The grounds are maintained seasonally by a landscaping company and the pest control company comes quarterly. Shelter rooms and bathrooms are inspected at a minimum of once per day for cleanliness, contraband and graffiti. All rooms are to be well lit and personal belongings are kept under lock and key.

This reviewer observed the program environment to be clean and well maintained. All health and fire safety inspections are current and up-to-date. The furniture in the facility was in good repair. The outside of the

facility was well landscaped. There were no issues to note during the walk-through and further inspection of the bedrooms and bathrooms indicated that the facility was kept in order. The beds were made and the rooms were free from clutter. The lockers and storage bins were neat and orderly. There was no issues with the lighting.

The bathrooms were clean with no odor or smells emanating from them. The showers were clean with mats to guard against slipping in the shower. There was no graffiti seen during the review. Personal belongings of the youth were locked in place in the living room area. A schedule is posted in the shelter that lays out structured activities to include homework time, groups and leisure activities. Physical activities can be provided in the backyard where there is a basketball hoop and volleyball net.

There were no exceptions noted for this indicator.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The program's policy is in congruence with the Program Orientation Indicator.

The program's procedure for orientation involves providing a comprehensive Residential Handbook to the child at intake. This provides the youth with a brief description of the program, an explanation of HIPAA and confidentiality, a brief description of safe place, client grievance process, a diagram of the facility's layout, a list of Shelter staff and their job titles, clients rights and responsibilities, house rules and disaster preparedness instructions. During the intake the youth is interviewed to gather information that is pertinent to the youth's safety and welfare while at the Shelter.

There were eight (8) files reviewed for program orientation. Four files were active and four files were closed. There were no issues or exceptions to note. In all 8 cases the youth and parent were provided with a handbook that they signed for during the intake. The handbook is a comprehensive review of program activities and rules. All documents reviewed contained youth and parent/guardian signatures. A physical facility layout is provided in the handbook along with emergency/disaster procedures.

There were no exceptions noted for this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy that addresses all the requirements for the Youth Room Assignment Indicator.

The program's procedure requires staff to complete the CINS/FINS Intake Form and entire intake packet at the time of admission. The information gathered will assist in determining the most appropriate room assignment. If possible additional information will be gathered from collateral contacts. Room assignments are based on age, maturity level, presence of any disabilities, gang affiliations or behaviors, apparent emotional, mental health or substance abuse issues, and presence of any aggressive behaviors. Generally youth are placed determined by their age groups: 10-12, 13-15 and 16-17.

There were eight files reviewed for youth room assignment. Four files were active and four files were closed. In each case the program used the CINS/FINS Intake Form provided by the Florida Network. This form captures each area of the indicator with the exception of gender identification, which would be best practice. The required areas on the form were filled out to address all applicable areas. Observations for each youth and the reasons for their room assignment were documented in the summary observations/comments. Alerts for the youth were documented on the spine of the folder as well as on the Alert System Shelter Checklist. In seven of eight files, there appeared to be collateral contact with one exception when the parent was unable to be reached to sign the intake paperwork.

There were no noted exceptions for this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy that addresses all the requirements for the Log Books Indicator.

The program's policy is to utilize a log book to document routine daily activities, events and incidents in the program. It is a running document of daily activities that occur in the Shelter. The entries in the log book should be brief and factual and reflect the behavior of the youth and actions by staff. Entries are to be completed in ink and show the date and time of an incident or activity. It should indicate the name of the youth and staff involved and must have the signature of the staff involved. All recording errors are to be struck through with a single line and initialed by staff.

The log books are to be reviewed by the Shelter Manager or designee. Incoming staff are to review the previous two shifts upon coming on to their shift. Log book entries are made every fifteen minutes. Log books are kept in storage for seven years.

The program has a log book where all entries are written in ink and are legible. Recording errors are not scribbled out and there is no use of white out. The program has a color-coded system where specific types of entries are to be highlighted. The coding system is blue for sign-in and sign-out, green for general knowledge, orange for appointments, pink for emergencies and yellow for the census. Safety and security issues and incidents are documented in the log book. The Residential Manager conducts weekly reviews of the log book.

It is important to note the agency has a total of three staff members working on the overnight shift. The overnight staff are completing bed checks every 15 minutes or less. The reviewer of this indicator reviewed camera surveillance footage to verify and confirm the completion of resident bed checks every 15 minutes or less. The reviewer of this indicator found that each staff member is conducting bed checks on an intermittent basis. Some staff members are completing checks every 5 to 10 minutes and others are completing the checks every 15 minutes.

A review of logbook documentation of the checks was also conducted. The documentation of resident bed checks contained some discrepancies. Review of the logbook revealed that some staff are documenting logbook checks while others are not. The inconsistency is that some logbook documentation reflects that bed checks have been conducted every five minutes. Other bed check documentation entries reviewed in the logbook found that these bed checks were in excess of 15 minutes.

Exceptions:

Staff are not consistently signing in and out of the log book as well as not indicating that they have reviewed the previous two shifts. It is very difficult to ascertain when staff arrive at the Shelter and when they leave since they are consistently not signing in and out of the log book.

Staff are not documenting the bed checks accurately and on time. Documentation reviewed reflects that some staff completing bed checks are documenting the entries in the logbook while other staff completing bed checks are not actually documenting in the logbook. This lack of documenting bed checks in the logbook reflects inconsistent documentation of bed checks largely due to staff not writing bed check entries in the logbook each time a staff member completes. Staff should document bed checks each time or communicate to another staff member to document in the log book when an actual bed check has been completed.

In addition, they are not consistently using their color-coded system.

Two out of five CCC Reports were not documented in the log book.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

Lutheran Services has a written policy that addresses all the requirements for the Behavior Management Strategies (BMS) indicator.

The program has procedures in which the BMS is explained to the youth at intake. The BMS is clearly explained in the handbook. The program uses a Behavior Management Sheet to document the youth's progress on a daily basis. The BMS is designed to gain compliance with program rules and change behavior through accountability. The program utilizes a wide variety of rewards and appropriate consequences and sanctions to gain compliance. The BMS is a token economy of phases that are used to encourage youth to increase positive and decrease negative behaviors. All staff and supervisors are trained in the BMS and feedback from youth and staff is encouraged.

The program has a detailed description of the BMS in the handbook that is distributed to the youth and parent at intake. The program uses a Behavior Management Sheet that keeps track of the youth's progress through the BMS. The BMS is designed to address behaviors and encourage participating in the program. Consequences and sanctions that are used by staff include early bed time, loss of privileges, sit time where the youth write a letter on various topics, goal setting and use of "I" statements. Rewards for positive behavior include access to a prize cabinet, later bed times, increased phone calls and outings. Staff are trained in the BMS. There is a white board in the day room that indicates the phase a youth is on, along with any loss of privilege or other sanctions.

There were no exceptions noted for this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

Lutheran Services has a written policy that addresses all the requirements for the Staffing and Youth Supervision indicator.

The program has a procedure that complements the policy. The program adheres to the staffing ratio of 1 to 6 and 1 to 12 overnights. The program has a schedule that is posted and actually have three staff on overnight shifts at times. A phone list is maintained in the office for on-call situations. Both male and female are scheduled. Staff are required to observe youth every fifteen minutes during sleep time.

The program follows policy for staffing and supervision requirements of 1 staff for every 6 youth during

awake hours and 1 staff to 12 youth during sleep hours. The overnight shift maintains two staff being present and even have three scheduled at times. There are staff of both genders scheduled and on duty. The staff schedules are posted in place and there is a rotation roster that includes numbers to reach staff when coverage is needed.

Staff are documenting bed checks a minimum of every 15 minutes in the log book.

Exception:

It appears as though the program is adhering to the staffing and supervision requirements, however it is very difficult to ascertain when staff arrive at the Shelter and when they leave since they are consistently not signing in and out of the log book. When staff document the census they are indicating what staff is present, but it is difficult to determine when a staff actually arrived or when they left. Due to these issues it cannot be determined if there is staff within ratio with the youth at all times. It can be surmised that they are within ratio each shift due to it being documented on the census report.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

Lutheran Services has a written policy that addresses all the requirements for the Special Populations indicator.

The Shelter's staff secure services may be provided to court ordered youth who are in contempt of court for continued running away or are locked out of their home due to a history of ungovernable behavior. These services provide more intensive staffing and individualized services than traditional CINS/FINS. Referrals for staff secure services come through the court on a CINS petition. Staff secure services can last up to 90 days in Shelter with a possible 30 day extension.

Domestic Violence Respite services may be provided for youth that have been charged with Domestic Violence, but that don't meet criteria for secure placement. DV Respite cases must be initiated by the JAC Center. Approval for providing these services must be sought from the Florida Network. DV Respite services do not exceed 21 days. Goals for the youth should be designed to address aggression management, family coping skills and other intervention to reduce violence in the home.

Probation Respite services may be provided to youth on Probation whose Adjudication has been withheld. Referrals must come from a Juvenile Probation Officer. Many factors are considered to include seriousness of past charges, behavior history, current population, bed availability, etc. Referrals are submitted through the Probation Referralator via the Florida Network and approval must be received prior to accepting the youth. The length of stay is determined at the time of admission. Length of stay is 14 to 30 days.

Domestic Minor Sex Trafficking services are designed to serve domestic minor sex trafficking youth approved by the Florida Network who may exhibit behaviors which require additional supervision for the safety of the youth or the program. All requests may be approved for a maximum of 7 days. Approval for the youth to remain in the Shelter may be obtained on a case by case basis. Trafficking youth are encouraged to stay at the Shelter to receive services.

There were three files reviewed for Domestic Violence (DV) Respite. All three files reviewed indicated that the youth had been screened at the JAC for a DV charge, but did not meet criteria for secure detention. None of the files reviewed had youth who had a length of stay over 21 days, therefore none were transitioned to CINS/FINS or Probation Respite. Two of the three files contained case plans that focused on aggression management, family coping skills and other interventions to address violence in the home. The third file was a youth who was discharged after one day and a case plan was not developed. All other CINS/FINS services were provided to the youth as well.

There were two files reviewed for Probation Respite (PR). In both cases, there was evidence that the FNYFS was contacted for approval prior to admission. In one of the two files, the length of stay for the youth on PR was not discussed with the JPO prior to admission. In both cases the length of stay was less than 14 days so there was no need for approval from the JPO. In both cases there was evidence that the youth's case management and counseling needs were met by the program. They also received all other services afforded to CINS/FINS youth.

There were no staff secure or Domestic Minor Sex Trafficking cases to review.

Exception:

In both cases reviewed for Probation Respite there was no documented conversation with a JPO about placing a youth at the Shelter for PR. In one case it appears as though the referring source on the screening is the JPO, but there is no documentation of this interaction other than on the screening and there are no other subsequent contacts with the JPO documented. The youth came to the Shelter after spending 21 days in secure detention. In the other case the referral source on the screening indicates that the mother is the referral source. However, there is paperwork from DJJ placing the youth on Home Detention for 15 days. There is also an Intake/Probation Youth on Non-secure Detention Youth document from DJJ. According to the notes from the Counselor the youth was brought to the Shelter after a DCF investigation following a Probation Violation. In each case, a formal documented conversation with a JPO needs to be documented.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy that addresses all the requirements for the Video Surveillance System indicator.

The program has a procedure in place that complements the policy. At the present time, the video surveillance has the capability to retain video for 21 days instead of the 30 day requirement. The cameras do record the date, time and location. The cameras do provide for facial recognition. The cameras are reviewed bi-weekly and those reviews are kept in a separate log book. The cameras are maintained in the interior and exterior in high traffic areas.

The program has a video surveillance system that monitors both the inside and outside of the facility. There is a generator that powers the system should there be a power outage. The cameras are visible and a notice is posted that there are cameras on the premises. The video surveillance appears clear and allows for facial recognition.

Two staff members (Residential Manager and YCS III) have access to review the cameras for activities. There is a separate log book that contains reviews completed every 14 days by those supervisors. There is a mechanism by which video footage can be copied to a flash drive for third party reviews.

Exception:

At the present time, the video surveillance system has access to 21 days of video. Per the indicator, 30 days is required. The Residential Manager provided an e-mail that indicated communication with an ADT Representative that addressed issues with DVR space.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

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

Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The shelter manager and/or Youth Care Supervisor is 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 in the daily log, on the alert board, shift exchange forms, and in the youth files using a color coding system.

Youth admitted to the shelter with prescribed or over-the-counter medication surrender those medication to staff during admission. Medications are stored in the Pyxis MedStation 4000 Medication Cabinet, and topical and/or injectable medications are stored separately from oral medication. The provider installed the Pyxis Medication System and has trained their staff to use it. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication and ensures that an approved staff is scheduled on each shift. Medication records are also maintained for each youth and stored in a MDL (Medication Distribution Log) Binder.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy that is identical to the Healthcare Admission Screening indicator. The policy was signed and reviewed last by the Executive Director, Clinical Director and Shelter Manager on August 24, 2016.

The program ensures that the CINS/FINS Intake Assessment Form is completed upon intake to assess youth for any medical issues. The nurse is to complete a healthcare screening when present during intake and if the nurse is not present, staff complete the screening and the nurse will review within five business days.

The program has a procedure in place in the case a medical referral needs to be made or follow-up for a medical need is necessary.

Five (5) open files and three (3) closed files were reviewed. All files contained the healthcare screening and were completed on the day of intake. Seven (7) of the files contained healthcare screenings that were either completed by the nurse or if completed by the staff, the nurse documented it was reviewed and the date it was reviewed.

The program's healthcare screening includes all the required information.

Exception:

One file did not have the nurse documentation of a review after the staff had completed the healthcare screening.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy called Suicide Prevention that aligns with the indicator. The policy was last approved by the executive director on September 17, 2015 and the clinical director, as well as the residential services manager on August 24, 2016. The policy includes exact content and language referenced from the Florida Network policy of the same name.

The agency is required to screen each resident admitted to the youth shelter and its residential program in accordance with the policy and procedure manual for CINS/FINS clients. The suicide risk rating is included in the intake form and is used during the screening process at the time of admission. The screening form has a section that screens for past and current existence of suicide risk. Questions one through six screen for present existence and the status of suicide risk. Every client admitted to either program is required to be screened for suicide risk. Each direct care worker in the residential shelter has been trained to administer the suicide risk screening questions to each client. All staff must follow the process of a screening protocol and if any of the clients receive a positive on one of the re-screening questions they are required to place the client on sight and sound supervision until they are seen by a residential counselor.

Staff are then required to monitor the status of the youth's behavior while on one-to-one supervision or constant supervision status. Staff are then required to document these behavior changes or regular status of the client on an observation log every thirty minutes or less. The client is required to stay on the screened supervision level and not change that status or reduce the status until a professional licensed clinician can complete a further assessment.

The agency has developed and produced documents and provide training that allows each staff member to assess, respond, report and document any suicidal behaviors communicated or demonstrated by the resident. The agency is required to utilize standard protocol set by the state-wide suicide risk response protocol that was developed by the Florida Network of Youth and Family Services to deal with any circumstance pertinent to suicide prevention that occurs while the child is in their care.

Each residential counselor is a Masters level counselor. One of the two counselors is currently a registered intern to become a licensed mental health counselor. The second Masters level counselor is in the process of becoming a registered intern to become a licensed mental health counselor. Each counselor has completed the 20 hours of assessments training. Those hours completed have been overseen by the agency's licensed clinical social worker. The agency's licensed clinician has a clinical license that is in effect through March 31, 2017 (verified through copy of the license presented at review).

A total of seven cases revealed the following results. The agency conducts a suicide risk screening during the initial intake and screening process. This is found to be the case in all seven cases reviewed. The screening results of each suicide risk process administered on each client included a review of the results that were signed by a counselor or direct care staff member completing the screening and a manager or supervisor or clinician that had reviewed the accuracy of the form. All seven client files had a minimum of one positive suicide risk indicator documented on their respective CINS/FINS Intake forms.

Each client that had a positive suicide risk indicator documented, also had documentation that they were placed on sight and sound supervision. Each file included evidence of suicide observation checks being completed by a staff person every 30 minutes or less.

All seven client files also had evidence that a suicide risk assessment had been completed by a non-licensed staff being overseen by a licensed professional who was in charge of the agency's suicide prevention program. Each youth had documentation that they had been placed on the appropriate level of supervision based on the results of the suicide risk assessment. Each client file reviewed had a determined supervision level that was not changed unless it was initiated by a counselor.

Exceptions:

The reviewer requested a sample size of all residents that screened for suicide risk in the last 6 months. From this list the reviewer randomly selected a total of seven (7) files to assess the agency's practice related to Suicide Prevention. Of these files, five (5) out of the 7 had at least one or more exceptions identified during the case file review. One (1) out of the 7 client files were found to lack evidence of client observation logs. One of the client files was missing evidence of Sight and Sound observation logs for 2 work shifts (2nd and 3rd shifts on 11/30/2016).

Five (5) out of 7 client files reviewed contained case notes that do not document evidence that the counselor has consulted directly over the phone or in person with the licensed clinician overseeing the assessment process with enough clarity that the selected Precautionary Observation had been approved. The documentation does not provide a mitigating reason justifying a lack of definitive confirmation of the type of contact the non-licensed clinician is confirming with the licensed clinician overseeing the process to verify and confirm the change of the status of the Precautionary Observation.

One out of the 7 client files reviewed had incorrectly marked the incorrect Precautionary Observation status. The form indicated that the child's Precautionary Status was "Continue youth on Precautionary Observation". However, the correct status of "Discontinue Precautionary Observation and place youth on standard Supervision" was not marked as required.

One out of 7 client files reviewed had inadvertently not communicated the Discontinue Secure Observation and transition youth to Close Supervision status change in a reasonable amount of time. The counselor documented the change on the Suicide Risk Assessment and in their progress notes on January 17, 2017, but failed to notify the shelter staff that continued to document five minute observations log checks until January 20, 2017.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedures that addresses the safe and secure storage, access, inventory, disposal, and administrative distribution of medications.

The program has procedures that include the following requirements. The agency will utilize trained staff members to execute and store, conduct inventory, document and distribute all medications. Staff that are authorized to assist in the delivery of the medication must be trained by a Registered Nurse. The Registered Nurse is the designated licensed authority overseeing the work place practice of all non-licensed staff members who assist clients with the delivery of the client's own medications on an as needed basis during their shelter stay.

The program has medications that are stored in the Pyxis MedStation 4000 medication cabinet. All medications are stored there. The current medication cabinet is not accessible to residents. The medication cabinet is stored in a locked room behind a locked door. The medication door is a split door with the top half divided from the bottom half. The bottom half has a ledge to prepare and assist in the delivery of medications to each resident. The residents never enter the area where the MedStation is stored; the divider creates a barrier that prevents them from entering the area. All oral medications are stored separately from injectable and topical medications.

The Pyxis MedStation utilizes all five (5) trays. Tray number one houses over-the-counter medications. Trays two through four houses all prescription and controlled medications. Tray number five houses observation equipment including a blood pressure machine, heart rate detection machine, a pulse occimeter and a temperature machine.

The agency has a list of all staff that are authorized to distribute medications to clients. There are a total of eleven staff authorized to assist in medication delivery. The agency maintains a total of three super users

for the MedStation. The super users include the registered nurse, the program shelter manager and a YCS II staff. The program maintains a miniature refrigerator in which all medications require refrigeration are stored. The mini-refrigerator is secured with a pad key lock on the outside. At the time of this on-site program review, there were no clients that had medications which required refrigeration. The temperature of the refrigerator was 36°.

The agency stores narcotics and prescribed medications as well as over-the-counter (OTC) medications and the Pyxis MedStation cabinet. The agency maintains shift-to-shift counts that is verified by a witness on each shift change. These shift-to-shift counts are conducted for all controlled or narcotic medications three times per day. All over-the-counter medications are only accessed by authorized staff and are inventoried on a weekly basis. The agency conduct accounts of OTC's one time per week on the overnight work-shift.

The agency also uses a paper-based medication distribution log (MDL). The MDL is used to document the distribution of medication by all licensed and non-licensed staff assisting in the delivery of medications to clients.

The agency employs a part-time registered nurse. The nurse was hired in July 2015. The nurse conducts monthly reviews of medication management and delivery practice. The nurse also is the primary source of all medication distribution training for all staff employed by the agency. The nurse provides refresher and formal trainings of all staff as needed. The nurse also conducts a monthly practice and reviews the knowledge portal for the Pyxis MedStation and generates reports accordingly. The nurse also reviews the Pyxis MedStation for any discrepancies. Discrepancies are required to be cleared after each workshop. A staff member with a witness must clear all discrepancies prior to the end of their work shift.

The agency uses the four step method to verify medications as required by the Florida Network operations manual. The agency contacts the pharmacy and verifies the medication and documents the results in the clients' file. When the nurse is on duty, the nurse performs all medication distribution to the client. The nurse also conducts several general medical screenings to verify the status of the clients' health in the shelter.

The nurse also inspects the first aid kits inside the shelter medication room. First aid kits are replenished by ZEE medical. (ZEE medical is a private first aid company that performs first aid kit replenishment.)

A review of the medication distribution practice was conducted on-site. The methodology used to conduct this review consisted of a review of the storage and medication practices. The review included viewing medication cart documentation and discrepancy clearance practices; review of reported medication errors; review of sharps; review of six medication distribution logs; review of ability to operate the Pyxis MedStation 4000 cabinet. Also, a review of the medication distribution practice was observed during the evening shift (at 8:00pm) on Day 1 of the QI program review. The reviewer witnessed a Medication Pass session for two (2) CINS/FINS clients. The Medication distribution was handled by the Registered Nurse. The RN executed the medication pass with each resident-- providing and meeting all requirements for a safe and orderly distribution of medication as required. No concerns were observed during this session.

A review of the sharps manual revealed that the agency conducts sharps counts once per week on the overnight shift. The sharps inventory documents weekly counts of items including 3 wire cutters, 3 knife-for-lives, 38 razors, 3 scissors, 7 art/deco scissors and 11 knives. The record also documents that there are 40 butter knives and 4 spreaders. All counts are documented and accurate through verification of what is written in each weekly inventory count.

Exception:

A medication error was reported to the DJJ Central Communications Center (DJJ CCC) by the agency on September 2, 2016. The incident reported that a staff member mistakenly gave a shelter CINS resident more than the dosage requirement. Youth was one half tablet short of her prescribed medication. The reviewer requested documentation of Administrative follow-up protocol by the agency for this medication error. The reviewer contacted the agency's Registered Nurse regarding this incident. The Nurse verified and confirmed that she came in and reviewed plus re-trained the staff person involved on medication distribution protocol and practice. A review of the staff member's file was conducted. The Program

Services Manager provided evidence documenting retraining of the said staff member by the agency's Registered Nurse to address mistakes leading to the recent medication distribution error.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy that addresses the Medical/Mental Health Alert Process. The current policy mirrors the Medical/Mental Health Alert Process indicator with the same name. The policy was last reviewed on August 24, 2016 by the Shelter Manager.

The agency has developed a process to identify medical and health alerts that accompanies the client upon screening and transitioning into the residential shelter and general non-residential program.

The program follows procedures to screen each client upon entry into the residential program by using a legend that is color-coded with various number of alerts. The total number of alerts included in the LSF alert system shelter checklist is a total of ten. The alerts included in the system include medical condition, sight and sound, elevated supervision, allergies, medication, medication side effects, substance abuse, mental health, physically aggressive, and chronic run away.

The agency utilizes the system by adding a legend in the front of every three ring binder. Each client has a file with a three ring binder that includes a legend with all ten alerts by color and definition. The program instructs all staff to follow the alerts and add a colored dot to the outer spine of a client binder.

A review of seven client files of active clients was conducted on-site during the program review. All seven client files have a colored dot that matches the alert risk identified during the screening process. All client files had at least one risk indicated as an alert. Four of the seven files included dots that had suicide or elevated supervision risk identified.

There were no exceptions noted for this indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy for the provision of emergency medical and dental care. The policy was last updated on July 22, 2016.

All staff is to be trained and certified in first aid and CPR during their initial orientation period. All staff are recommended to and provided training on safety measures including emergency response, first aid, fire safety, blood-borne pathogens and general emergency medical response.

All staff members are required to call emergency contact numbers for situations that require immediate first aid or more serious level of care for emergency-based incidents.

A review of all incidents for this indicator found that no incidents met the emergency requirement for the last six months. All care provided to clients only required first aid assistance.

Agency has a corresponding emergency care or incident log binder to document all applicable incidents. The agency did provide documentation of summarized Emergency Care Logs documenting thirteen (13) emergency care incidents involving shelter residents in the last six (6) months. In addition, the agency

provided documentation of all Oasis Mock Emergency Drills conducted in the last 6 months. The documents reviewed revealed mock drills that occurred on November 29, 2016, November 7, 2016, November 5, 2016, October 8, 2016, September 7, 2016, and August 30, 2016.

Agency does provide several emergency and incident response trainings for staff in the event of an emergency. Agency training includes CPR and first aid, fire safety, universal precautions, abuse reporting and several others.

Exception:

The documentation practice of notifying parents/guardians when emergencies occur is inconsistent across the thirteen incidents documented in the last six months.