



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of LSF NW- Hope House

on 10/04/2017

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

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

Standard 3: Shelter Care

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

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

Standard 2: Intervention and Case Management

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

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

Standard 4: Mental Health/Health Services

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

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

Percent of indicators rated Satisfactory:96.30%
Percent of indicators rated Limited:3.70%
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, FNYFS/Forefront LLC Warren Garrison, Operational Review Specialist, Department Of Juvenile Justice David Gray, Training Coordinator, Hillsborough County Children's Services Cynthia L. Starling BA CPP CAP, CDS East, Regional Coordinator

Persons Interviewed

- | | | |
|---|--|---|
| <input type="checkbox"/> Chief Executive Officer | <input checked="" type="checkbox"/> Executive Director | <input type="checkbox"/> Chief Operating Officer |
| <input type="checkbox"/> Chief Financial Officer | <input type="checkbox"/> Program Director | <input 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 type="checkbox"/> Case Manager | <input type="checkbox"/> Advocate | <input type="checkbox"/> Human Resources |
| <input checked="" type="checkbox"/> Nurse | | |
| 1 Case Managers | 0 Maintenance Personnel | 1 Clinical Staff |
| 2 Program Supervisors | 1 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 checked="" type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input checked="" type="checkbox"/> Key Control Log | <input type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Fire Drill Log | 6 # Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 7 # MH/SA Records |
| <input checked="" type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 0 # Personnel Records |
| <input checked="" type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 0 # 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 | 4 # Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

1 Youth 3 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 type="checkbox"/> Tool Inventory and Storage | <input checked="" type="checkbox"/> Facility and Grounds |
| <input checked="" type="checkbox"/> Recreation | <input type="checkbox"/> Toxic Item Inventory and Storage | <input checked="" type="checkbox"/> First Aid Kit(s) |
| <input type="checkbox"/> Searches | <input type="checkbox"/> Discharge | <input type="checkbox"/> Group |
| <input 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 checked="" type="checkbox"/> Youth Movement and Counts | |
| <input checked="" type="checkbox"/> Medication Administration | <input checked="" type="checkbox"/> Staff Interactions with Youth | |

Comments

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

Rating Narrative

Strengths and Innovative Approaches

Rating Narrative

Lutheran Services Florida Northwest (LSF NW) HOPE House has accomplished many achievements since the last quality improvement visit:

- They launched the use of the electronic logbook, NoteActive, in April. It has been a major change for them.**
- They welcomed Nurse Rose Leno to their team.**
- Their community food program has grown tremendously. They are able to provide food and other daily needs for 488 households.**
- LSF NW continue to have monthly Cultural Celebrations for their shelters. They learn about a different culture each month throughout the month and the celebration culminates with a dinner utilizing recipes from that country (and when available a speaker from that country).**
- This year's After School Bash carnival became the End of Summer Bash for the youth celebrating going back to school and the end of summer.**
- They had a bake sale fundraiser for a staff event – the annual Youth Care Staff Retreat – and the youth helped bake and decorate cakes and brownies.**
- The staff took youth to Panama City to Wonder Works – an adventure house/hands on museum. The youth had a great time.**
- Their youth have had the opportunity to learn a variety of skills this year. They have learned to do comparison shopping, house hunting, baking, cooking, gardening, organization, and many other things.**
- The United Way Day of Caring volunteers came recently and re-mulched LSF NW HOPE House's front yard, painted the upstairs bathrooms, and pressure washed the concrete around the building.**
- Also, HOPE House was selected to be one of the programs to provide Intensive Case Management Services.**

Standard 1: Management Accountability

Overview

Narrative

Lutheran Services Florida (LSF) Northwest operates both the HOPE and Currie House Shelters (Residential) and Non-Residential CINS/FINS Program located in Escambia, Santa Rosa, Okaloosa, and Walton County, Florida and is also the designated CINS/FINS provider for Escambia, Okaloosa, and Santa Rosa Counties.

Staff at the program are comprised of a North Region Director; Clinical Director that is a licensed Mental Health Counselor; two counselors; a Residential Services Manager; Residential Direct Care Staff, Administrative and Maintenance staff.

The Regional Director oversees the operations and duties at the shelters. The director, provides oversight and supervision of the direct care workers that are responsible for the CINS/FINS residential and non-residential programs as well as other programs operated by the provider in the Northwest Region.

The program has an Annual Training Plan for each staff and orientation training is provided to all new hires. LSF Northwest maintains multiple outside partnerships to provide various community agencies that ensure a continuum of services for its youth and families. The program has a highly active local food outreach program. In addition, the program has a regional outreach component across the service area. This program involves participation from staff and system partners to focus their outreach activities in designated high crime zip codes and low performing schools.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

In accordance with Chapters 20, 39, 435, 984, and 985 Florida Statutes, and the Department Juvenile Justice (DJJ) statewide procedure on background screening for employees, providers and volunteers, and interns meeting good moral character standards may be hired. The program's policy reflects these guidelines.

According to the program's procedures, the background screening check must and shall be completed prior to making an offer of employment to an applicant. The background screening is valid for 180 calendar days.

A total of nine personnel records were reviewed. Three staff (part-time registered nurse, part-time youth care specialist, and counselor) members were hired since the program's last quality improvement review. Each applicable background screening was completed prior to their hired date. Each of the three new employees did not begin their orientation and new hire training until after the background screening was returned with eligible results. The Annual Affidavit of Compliance with Level 2 Background Screening was completed, signed, notarized, and submitted on January 5, 2017.

There are no exceptions noted for this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program's policy states the program must provide an environment in which all youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment.

All staff must adhere to a code of conduct. Any person who has reasonable cause to suspect a child is abused must report such knowledge to the Florida Abuse Hotline. The program must have an established grievance process and management must act immediately to address all and any instances of abuse.

Nine personnel training records were reviewed. Each record contained an acknowledgement of the code of conduct and documentation of abuse reporting and abuse issues training. Each staff reviewed completed five hours of incident reporting and abuse. The Florida Abuse Hotline phone number is posted in the dayroom where the youth access majority of the day and the room is utilized by the counselors at the program. There was one complaint against staff on June 6, 2017. Management took immediate action to address the complaint against staff. The Central Communication Center (CCC) was contacted within the proper timeframe. There was one report of abuse since the last annual compliance review on April 28, 2017. The allegation of abuse was reported to the Florida Abuse Hotline immediately and CCC was contacted within the proper time frame.

The program has an accessible and responsive grievance process for youth to provide feedback and address complaints. The process delineated in their policy and procedure allows the youth to grieve actions of staff and conditions or circumstances related to the violation or denial of basic rights. Procedures instruct the youth care specialist not to handle the complaint/grievance unless assistance is requested by youth.

There are no exceptions noted for this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The program policy delineates the program's responsibility to report incidents. Whenever there is a reportable incident, the program notifies the Department's Central Communication Center (CCC) within two (2) hours of the incident or of gaining knowledge.

The general procedures are as follows: all reportable incidents are verbally reported to CCC such as medical incidents, mental health substance abuse incidents, complaints against staff, and youth behavior incidents. Two separate debriefs are conducted with the client and parent/guardian first and then with staff involved in the incident. And supervisors must provide a follow up.

There were a total of six incidents reported to the Department's CCC since the last annual compliance review. One of the six reported incidents was not reported to the Department's CCC within the proper time frame. Each incident was documented in the program log book.

Exception:

Staff gained knowledge of the incident of April 28, 2017; however, staff failed to notify the Department's CCC within the required two-hour time frame.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place to address training requirements. Training targets specific goals for staff in terms of numbers of hours and specific topics required.

Training may be provided by the Florida Network, local community resources, and various local provider. All staff are required to have a minimum of eighty hours the first year and twenty-four hours annually after the first year. All newly hired staff must complete all required training within 120 days of hire.

Three staff members were employed at the program for more than a year. One of three staff was employed long enough to complete the required twenty-four hours of annual training. The one staff completed all required training. The program maintains a folder with printouts labeled Lutheran Services Florida Individual Training Record. The folder also contains the required training for each staff member. Supporting documentation include: sign-in sheets, agendas, meeting minutes, and certifications.

Exception:

Each of the two newly hired staff were missing CINS/FINS Core training.

1.05 Analyzing and Reporting Information

Satisfactory Limited Failed

Rating Narrative

As noted in their policy, the program shall collect and review data from several sources of information to identify patterns and trends. The program must complete quarterly case record reviews, quarterly reviews of incidents, accidents, and grievances, annual customer satisfaction data, annual review of outcome data, and monthly NetMIS data reports. Findings should be regularly reviewed by management staff and communicated to staff and stakeholders. Strengths and weaknesses should be identified using the data collection.

Monthly case review reports must be completed for all Lutheran Services Florida (LSF) programs. Case review reports must capture safety, risk management, incidents, accident, and grievance issue. Reports are to document consumer satisfaction, outcome measures, and case reviews. Lastly, the case review reports must identify strengths and weaknesses within the program.

A review of the case record review report submissions since the last compliance review completed in January 2017, determined the program completed all required case record review reports. Each case record review report had all the required elements. Documentation of the program's monthly case record review reports captured incidents, accidents and grievances. Customer satisfaction was documented in the case record review report and was completed monthly. The outcome data sheet was completed for the quarter of April-June 2017 and the quarter of July-August 2017. Documentation of a case record review report for April 2017 was missing.

Interviews with the Regional Director during the entrance revealed on-going issues with male staffing and a low youth census. The case record review reports capture other strengths and weaknesses within the program but do not capture an initiative to increase the youth census or an attempt to employ any male staff.

There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.

There are no exceptions noted for this indicator.

1.06 Client Transportation

Satisfactory Limited Failed

Rating Narrative

The program's transportation policy is implemented by the agency approved drivers. The policy addresses the safety of youth being transported by staff. Drivers must be approved by the agency, have a valid

Florida driver's licenses, and approved drivers are insured. The policy allows for third party individual to be present during transportation and the policy addresses staff documentation when utilizing the vehicle.

Procedures include third party individuals present in the vehicle may be another staff member (an approved volunteer, an intern, or another youth), a valid Florida driver's license, and the use of a mileage log for every time the vehicle is utilized.

Since the program's last compliance review conducted in January 2017, the program has utilized the van 570 times. There were twenty-one instances when staff did not sign the vehicle log, ninety-nine instances when the staff did not completely log the time of vehicle use, and there were twenty-three instances when the driver did not log the mileage. The number of passengers and purpose of travel was documented correctly for each usage.

Interviews with the senior administrator determined all staff are eligible for transportation of youth, no staff is hired without having a valid Florida driver's license, and approved drivers are maintained on a Microsoft Excel spread sheet. Personnel records reveal all staff were hired with a valid Florida driver's license. Interviews with the senior administrator revealed there is no formal process for monitoring when a driver license may become invalid. Drivers licenses are monitored again after the initial hire date during the required five year background rescreening.

Exception:

Out of 570 usages, the vehicle log was completed correctly (vehicle notes name, date and time, mileage, number of passengers, and purpose of travel and location) ninety-three times.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

LSF-Hope House has a policy and procedures in place for Outreach Services. It was last reviewed on September 29, 2017. The program must participate in local DJJ board and council meetings to ensure CINS/FINS services are represented in a coordinated approach to increasing public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services. The program also must complete written agreements with other community partners. The agency must have an assigned representative to advocate for the effective use of CINS/FINS services.

Procedures include the Regional Director supervising services, developing annual strategic plans with specific projected prevention, outreach goals, objectives and outcomes, making efforts to target runaway and homeless youth and their families, participating in circuit level DJJ board and council meetings, outreach efforts, participating in an active role in the National Safe Place program, interagency agreements, and accountability.

The program provided documentation of fifteen interagency agreements. This is supervised by the Regional Director. The Regional Director, Clinical Director, Service Managers and Outreach Team develop annual strategic plans with specific projected prevention outreach goals, objectives and outcomes. Outreach efforts are made throughout Escambia, Santa Rosa, Okaloosa, and Walton Counties. The target audience includes runaway and homeless youth and their families as well as the community at large. Efforts are made through school presentations, community presentations, fundraisers, distribution of materials, and community events. Interviews with administration reveal program representatives attended two outreach services since the last annual compliance review.

There are no exceptions noted for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Lutheran Services of Florida Hope House (HH) Residential and Non-Residential Counseling Programs provide CINS/FINS counseling services for youth and their families in Walton, Escambia, Santa Rosa, and Okaloosa Counties in Florida. The program continues to maintain working partnerships with local service organizations. Hope House provide individual, group and family counseling services. The program offers an experienced Licensed Clinical Director and three other residential and non-residential counseling staff members who all have master level degrees. The Hope House program receives referrals from local schools, the Department of Juvenile Justice, and the Department of Children and Families as well as the local courts. Hope House also maintains office space at various community sites in the Florida Panhandle area.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that address all of the key elements of the indicator related to Screening and Intake. The specific policy was reviewed by the Regional Director on 9/29/17.

The policy provides that centralized intake services are available 24 hours/7 days a week. Centralized intake services include screening for eligibility, crisis counseling, information, and referral. The initial screening for eligibility must occur within seven calendar days of referral by a trained staff member using the NetMIS screening form. The policy includes the written items that are provided to the parents/guardians and the information that is available to families in need of services. The procedures for this policy are explained in detail.

A total of six files were reviewed for compliance of Standard two: three residential files (two open and one closed) and three non-residential files (two open and one closed). All six of the files reviewed contained screening and intake documentation. All of the screenings were completed within the seven calendar days of initial referral.

During the intake process, the parent/guardian is provided with a copy of the pamphlet "A Guide to CINS/FINS Services for Parents" which explains the CINS/FINS continuum of services and lists options for parents who are seeking services for their child who may be displaying ungovernable behaviors, running away, or truant from school. The parent indicates receipt of the pamphlet by their signature.

The "Client Informed Consent" is a written document that is explained to the family by staff and/or read by the client/parent. The informed consent explains the rights and responsibilities of the client, confidentiality, and the procedures for filing a grievance. The form has a signature line for the client, parent/guardian, and the staff member.

The three non-residential files contained the signatures of the client, parent, and counselor. The clinical residential files contain the youth signature and the counselors' signature. The parent signature are obtained at intake and are found in the residential files. The residential and non-residential program utilizes a "Youth Intake Form" which gives the incoming youth the opportunity to express in writing why he/she believes they are being enrolled in the program, three areas they would like to work on during their stay, their personal strengths, how they deal with personal problems and a recent success that they have experienced.

There are no exceptions noted for this indicator.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses the elements of the Needs Assessment indicator. The policy was reviewed on 9/29/17 by the Regional Director.

The agency's procedure indicates that the Needs Assessment is completed to gather and analyze information for all youth receiving services and it is required to be completed by a Bachelor or Masters level staff member and signed by their supervisor. The Needs Assessment must be initiated within 72 hours of admission into the residential program. For non-residential services, the Needs Assessment should be completed within two to three face-to-face contacts following the initial intake. There is also a comprehensive list of elements that must be included in the assessments. If it is determined that the youth has an elevated risk of suicide, a full suicide assessment must be completed by a licensed mental health professional or completed under the direct supervision of a licensed mental health supervisor with the appropriate signatures. The Clinical Director is responsible for training and supervising staff in the implementation of these procedures.

A total of six files were reviewed: three residential files and three non-residential files. All of the six files contained a Needs Assessment which were initiated within the required time frames and conducted by a Bachelor or a Masters level staff member. All of the six Needs Assessments were approved by the supervisor who is a licensed mental health counselor. Two (2) of the non-residential files contained an updated needs assessment in that the youth in each case had a prior, recent shelter stay. The two updated assessments were also signed by the counselor and supervisor. One of the six files indicated an elevated suicide risk screening. The youth was referred for a full suicide assessment which was completed and approved by a licensed mental health counselor. The three residential Needs Assessments were complete except for the section "Parent/Guardian Information". This section should indicate parent employment, insurance, mental health coverage, and emergency contact information.

There are no exceptions noted for this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure in place that addresses all of the key elements of the indicator relative to Case/Service Plan. The policy was reviewed on 9/29/17 by the Regional Director.

The agency's procedure requires the Service Plan to be developed with the youth and family within seven working days of completing the Needs Assessment. The plan is developed based on information gathered during the initial screening, intake, and assessment. The plans should contain clear identified needs and goals, the type, frequency, and location of services, the person responsible, the target and actual dates of completion, signature of the youth, parent/guardian, counselor, and supervisor and the date the plan was initiated. The procedure also outlines that the case plan will be reviewed every thirty days for the first three months and every six months thereafter to assess progress towards service plan goals.

A total of six files were reviewed: three residential files and three non-residential files. The files reviewed indicate that all of the case plans were developed within the allotted time frames. In fact all were completed on the same day as the completion of the Needs Assessment. The residential files and non-residential files contain Service Plans which include all of the required elements. Both residential files and non-residential files contained Service Plans that were written to address the individual needs of the youth and were also written to include measurable objectives. The three residential files did not include the parent/guardian signature on the Case Plan but were signed by the client, counselor and supervisor. All three of the

residential clients were discharged prior to the 30 day case plan review. Two of the non-residential files had all of the initial case plan signatures including the client, parent, counselor, and supervisor. One file was missing a parent signature.

Exception:

Two of the non-residential files were due for 30/60 day reviews but were initialed by the counselor only. The third non-residential file has been open since June 28, 2017 and the 30/60/90 day review was initialed by the counselor only. The counselor noted numerous missed appointments and documented a 90 day phone review with the client only. The counselor met with the youth for an individual session on two occasions and no parent/family session have been documented during this open case.

2.04 Case Management and Service Delivery

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedure in place that addresses all of the key elements relative to Case Management and Service Delivery. The policy was reviewed on 9/29/17 by the Regional Director.

The agency's procedure requires that every youth is assigned a counselor/case manager who will follow the youth's case and ensure delivery of services through direct provision or referral. The policy also cites the steps of the case management process which may include the following as needed: establishing referral needs, implementing the case plan, monitoring youth/family progress, providing support for families, monitoring out of home placement, referrals to case staffing committee, judicial interventions, and case termination with follow-up.

A total of six files were reviewed: three residential files and three non-residential files. All files reviewed were assigned a designated counselor/case manager. The counselor's notes indicated that referrals were being made as needed. There were two referrals made by the residential counselor and two referrals made by the non-residential. One residential youth was being referred for outpatient substance abuse evaluation/treatment and one residential youth was referred to the "Empower" program at CHS. The non-residential counselor made a referral to Celebrate Recovery and a youth was referred to Cope Center for a psychiatric evaluation. Both counselor document supports for families when needed and case plan implementation was demonstrated.

The files reviewed indicated the counselors are indeed monitoring the youth's/family progress and documenting the progress in the case notes and on case plans. The counselors did not make any referral to the case staffing committee and there were no requests by parents for a case staffing. Therefore no CINS petitions were filed with the Courts. The Clinical Director advised that truancy cases are addressed by the school district via civil petition in Truancy Court.

The residential 30, 60, day follow-ups are completed by the administrative assistant and subsequently filed in the client record. The non-residential counselor completes the follow-ups on his clients. Both closed files contained the appropriate 30 day follow-up documentation.

There are no exceptions noted for this indicator.

2.05 Counseling Services

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedure which addresses all of the key elements of the Counseling Services indicator. The policy was reviewed on 9/29/17 by the Regional Director.

The procedure outlines the case coordination, case file organization, confidentiality, chain of trust, and self-monitoring. Youth receive counseling services to address their needs as identified during intake and assessment. The individual case plan is developed to specifically address the needs and serves as the guide to counseling services. The residential program provides individual, family and group (5 per week) counseling services. The group counseling should be a structured group setting with a clear leader, relevant topic, youth participation, and 30 minutes or longer. Documentation of groups must include date and time, a list of participants, length of time, and topic. The non-residential program provides therapeutic community based services based on the needs identified in the Needs Assessment. The counseling services are offered in the youth's home, a community location, or the provider's counseling office.

A total of six files were reviewed: three residential file and three non-residential files. All files reflect that the youth and families are receiving counseling services that are consistent with the Case/Service Plan. The youth's presenting problems could be found documented in the initial screening form, the Needs Assessment, and in the Case Plan. The counselor's notes are written in a very clear, concise, chronological manner utilizing a SOAP format. The non-residential counselor is providing individual, and family counseling with the plan to complete each once per week or as needed.

All six files had documentation of "Staffing Notes" in the file to indicate the case had been staffed with a supervisor/clinical director and feedback was documented by the supervisor with her signature and date of the case staffing. There are instances where the parent/guardian did not participate in services but the counselors did offer and encourage parent participation. There was documentation of the counselors attempt to reschedule missed or cancelled individual and family sessions. The residential clients are receiving individual, family, and group sessions.

The residential group sessions during the past six months have covered various topics such as: anger management, healthy relationships, decision making, peer pressure, social media, HIV/STD, substance abuse education, and dangers of gang involvement. The group log book is well maintained and provides a brief description of the topic, date, time/length of time, counselor/leader name, and the participants who were present for the group session. The majority of the logs also contained a specific note as to the clients' participation in the group topic or activity.

There are no exceptions noted for this indicator.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policies and procedures in place which addresses all of the key elements of the Adjudication/Petition Process indicator. The policy was reviewed on 9/29/17 by the Regional Director.

The procedure indicates the required composition of a Case Staffing Committee which must include a DJJ representative, a CINS/FINS agency representative, and a school representative. Other representatives such as State Attorney, local health, mental health, social services, law enforcement, DCF representative, the youth and parents and others invited by the family are encouraged to be included in the Case Staffing Committee meetings. The policy ensures that a case staffing meeting is convened within seven days working days of a written request by a parent/guardian. The case staffing committee formulates a new or revised plan of service. The family must be provided within 7 working days a written report which outlines the committee's recommendations and the reasons for the recommendation.

The agency does not routinely hold case staffing committee meetings unless there is a written request by a parent. The Clinical Director advised that there have been no specific requests during the past year; therefore, no Case Staffing/CINS petitions have occurred within the past year.

There are no exceptions noted for this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy in place which addresses all of the key elements of the Youth Records indicator. The policy was reviewed on 9/23/17 by the Regional Director.

The agency adheres to confidentiality laws and maintains all client files in a secure room or in a locked file cabinet which must be marked "Confidential". The records that are transported must be in an opaque container that is marked confidential. Youth records are to be maintained in a neat and orderly manner so that staff can quickly and easily access information. Procedure requires that all records are marked "Confidential" and that the agency maintain the strictest possible level of confidentiality for all clients. Therefore, at no time is information released concerning a client without obtaining permission from the parent/guardian. The exceptions to confidentiality are explained to clients through the Informed Consent document which is presented to the client and parent/guardian at intake. Exceptions to confidentiality are also explained to clients and their families.

A total of six files were reviewed: three residential and three non-residential. All six files were marked with a red stamp "Confidential" on the front cover and back cover of the file. The closed files are kept in a locked room and maintained in locked file cabinets which are all marked "confidential". The open residential files are maintained in the staff office in a locked filing cabinet. The residential files are not typically transported outside of the Hope House. Clinical files are separate from residential files until the residential file is closed and then residential records are integrated into the clinical file. Non-residential files are transported in an opaque, locked box type container that is marked "confidential". The non-residential counselor advised that the non-residential files are maintained in locked file cabinets which are located in a locked room.

There are no exceptions noted for this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The Hope House is licensed by the Department of Children and Families (DCF) as an eight (8) bed Child Caring Agency. The Hope House residential shelter provides short-term respite residential services to youth ages 6-17 years of age in the Department of Juvenile Justice (DJJ) CINS/FINS program. The shelter also serves youth referred from the Department of Children and Families. The Hope House youth shelter is capable of serving Special Populations youth including Staff Secure, Domestic Violence, Probation Respite, Human Minor Sex Trafficking, and Intensive Case Management populations.

The shelter program management team is comprised of a YCS III Shelter Supervisor, two YCS II's and four YCS direct care staff members, the shelter is in the process of hiring more YCS direct care workers, and a Registered Nurse (RN). Each shift also has YCS that is the designated team leader. There is also one residential counselor.

The program has policies and procedures in place for its Shelter Care programming. The Direct Care workers are responsible for completing all applicable admission paperwork, conducting youth orientation to the shelter, and providing necessary supervision. Health and medication-related activities are the responsibility of the Registered Nurse (RN).

Oversight of clinical mental health services is provided by the agency's Licensed Mental Health Clinician.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The policy covers all fourteen areas identified in the Florida Network indicator. Hope House's procedure is to provide a safe and healthy environment for the youth in shelter care. The policy covers shelter facility and grounds, kitchen and dining areas, bathrooms, sleeping quarters, linens/bedding, structured activities, client safety, physical activities, and faith based activities, and homework and reading.

The agency has a policy in place, 3.01 Shelter Environment, which is located under section 3.0 Shelter Care. This policy was last reviewed/approved on September 29, 2017.

Hope House is an eight bed shelter located off a side street in a residential neighborhood which appears to be centrally located in the community. The shelter is a residential home which has been converted into a shelter. The shelter is nicely painted and decorated.

The outside of the building is nicely painted and appeared to be well maintained. There were no structural concerns noticed. There is a fence around the back and both sides of the property.

There were no signs of graffiti on any of the walls, doors, floors, or furnishings. This included the bathrooms, bedrooms, hallways, offices, dayroom, kitchen, and the outside of the building.

There were no visible signs or concerns regarding insect infestation, which included the kitchen, dining room, dayroom, offices, bedrooms, bathrooms, and the outside grounds. In the kitchen, the inspection included looking around the appliances, behind the door, and the cabinets.

The facility has three bedrooms; at the time of the visit one room was designated for males and the other two rooms for females. The male room has four beds; each bed had a mattress, sheet set, pillow, and blanket. The other two bedrooms have two beds each; each bed had a mattress, sheet set, pillow, and blanket. The beds were all made and linen appeared to be cleaned.

According to the staff, the linens are changed weekly and at the time a youth is discharged the beds are stripped and clean linens are placed on the bed for the next youth. On one of the beds not currently being used, there was a card on the pillow saying Welcome. All the shelter's furnishings appeared to be in good

condition; this included the dining room, dayroom, and bedrooms. There were no identified broken or unusable furnishings during the review. The furnishings did not appear to be vandalized or have any signs of graffiti.

In the dining room there were two tables placed together to make one large table where everyone eats together. There's a fully functioning kitchen; including a gas stove, multiple refrigerators and freezers, and storage areas. In the dayroom the youth have access to books, board games, and video games.

The three bedrooms at the shelter are set up accordingly; one bedroom is set up for four youth and two bedrooms are set up for two youth each for a total of eight beds for the shelter. Each room had the appropriate number of furnishings, one bed and one dresser per youth, depending on how many youth are in the room. The beds and dressers all appeared to be in good functioning condition, no broken parts.

At the time of the visit, the bedroom with the four beds was designated for males and the other two were designated for females. According to the shelter, they are able to adjust the bedroom configuration as needed depending on population. The facility has two bathrooms for the youth; one is located in the male bedroom and the other one is located in the hallway area outside of the bedrooms. This bathroom is designated as the female bathroom. The bathrooms looked and smelled clean. The male bathroom has a shower, toilet, and two sinks.

The female bathroom has a shower, toilet, and sink; which all appeared to be functioning properly. The showers all had curtains. There were no signs of mildew. Each bathroom had a functioning vent fan. Throughout the facility the lighting was appropriate. The kitchen, dining room, dayroom, offices, hallways, bedrooms, bathrooms all had lighting appropriate to see clearly. All lights were observed to be functional. All lights turned on immediately when switched on.

The shelter has system in place to help secure important items of the youth in their care. There is a filing cabinet, which remains locked, which is used to store a youth's personal belongings. There is also a safe if there is a need to secure a youth's money. Both the cabinet and safe are in a locked staff office.

The shelter keeps a daily log sheet of the activities of the youth; these are categorized into education, recreation, life skills, crafts, outings, and physical activities. The staff completes this sheet each day of the week including weekends. For the youth who are not in school, the shelter has established daily educational time. They have a binder with structured activities for the youth to work on. The general daily schedule has specified time for multiple activities including reading and educational.

The facility also has scheduled outings listed on the staff schedules. The facility's general daily schedules are posted in the dayroom; one is for the week days, one is for weekends and holidays, and the other is for summer time. The facility does have physical activities of the day scheduled. According to staff, the youth go outside daily when weather permits. The general daily schedule reflects there is a voluntary Bible Study held weekly at the shelter. Staff also report, if a youth requests to attend Church they will make arrangements for the youth to attend.

The shelter has all its required safety inspections completed and all inspections were current. The Health Inspection was completed on 6/26/2017 according to the report there were no violations. The Fire Inspection was completed on 7/24/2017 according to the report, there were no violations. A Fire Detection and Alarm System Inspection was completed on 5/26/2017 according to the report, there were no issues.

There are no exceptions noted for this indicator.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place, 3.02 Program Orientation, which is located under section 3.0 Shelter Care. This policy was last reviewed/approved on September 29, 2017. This policy matches that of the

Florida Network.

Hope House's policy states that the orientation process is critical to successful placements. As a result the agency emphasizes the importance of the orientation process to all the youth and staff. Youth Care Staff are trained in how to develop a rapport with youth and provide effective orientation for new youth. A youth's first impression of shelter life is a critical factor in their later cooperation with the program. For this reason, youth are greeted with cheerfulness and warmth. Generally, orientation is conducted individually with the youth immediately following and clarifies any questions that may arise.

The completion of the intake documents are done by direct care staff at the time of the intake. The staff uses the Client Intake Checklist as a guide through the intake process. This is a detailed form which helps guide the staff through the process. The staff initials off as each section is completed. Once the form is completed, the youth signs the form as well indicating that each of the items on the list were reviewed or completed with them.

A total of six files were reviewed (three open and three closed). All six files had documentation that the youth received a copy of the handbook, reviewed disciplinary action, reviewed contraband rules, was given a tour of the facility, and a copy of the daily schedule/activities (elements were found on the Client Intake Checklist Form and Lutheran Services Florida Northwest Hope House Contract Form). Signed by the youth also were the grievance procedures (Grievance Procedure Forms), emergency/disaster procedures (Client Emergency Procedures Form), room assignment (CINS/FINS Intake Form), suicide prevention/alert notification (Client Safety Agreement; this is also signed by parent), and abuse hotline number (Client Right Form).

The parents signed the CINS/FINS Shelter Voluntary Placement Agreement and the Photo ID of Parent/Legal Guardian Prescription Consent Form. The parents were also provided with a Parent Handbook at the time of intake (this is documented on the Photo ID of Parent/Legal Guardian Prescription Consent Form). The youth was provided with a copy of the Client Handbook; which has copies of the daily schedules as well as provides documentation regarding the areas just reviewed with them.

There are no exceptions noted for this indicator.

3.03 Youth Room Assignment

Satisfactory Limited Failed

Rating Narrative

The Agency has a policy in place, 3.03 Room Assignment, which is located under section 3.0 Shelter Care. This policy was last reviewed/approved on September 29, 2017. This policy matches that of the Florida Network.

Hope House has developed procedures related to admission and room assignment to ensure the safety of all youth placed in agency residential facilities. Upon completion and approval of a NETMIS Youth Screening form, staff begins the shelter intake and makes an initial decision based on the youth's physical characteristics, maturity level, history (including gang or criminal involvement, exposure to trauma), and potential for aggression, and apparent physical, medical, emotional and/or mental health issues. The Youth Care Staff also considers the initial collateral contacts, initial interactions and observations of the youth. If there are immediate needs such as medical, hygiene issues, hunger or personal needs, the intake is temporarily postponed until those needs are met.

The shelter uses a number of forms to determine appropriate room assignment. This includes the CINS/FINS Form, Screening Form, Shelter Intake Assessment Form, and the Intake Snapshot Form. The facility also uses a colored dot alert system: orange-sight and sound, red-high risk (this category includes history of depression, running away, aggressive behavior, etc.), green-medication/medical, and blue are for DV. In addition, staff report they assess the other youth currently in the shelter: Have the youth currently in

shelter and the new youth been in shelter together before? What was the relationship? What are the reasons the other youth are in shelter and can that negatively impact the youth coming in?

A total of six files were reviewed: three open and three closed. All six files had documentation that staff assessed for the youth's history/past trauma, age, gender, history of violence, disabilities, physical size, gang affiliation, suicide risk, sexual aggression history, separation from siblings, and staff's initial observations. In addition, there was documentation of collateral contacts and the use of the shelter's alert system. The only area which is not specifically identified for assessment on a form is the youth's gender identity. According to staff interviewed, the shelter does follow up with the youth regarding this area during the intake process; which is typically done when completing the Shelter Intake Assessment Forms. The staff member reported it would be noted as needed on this form.

There are no exceptions noted for this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that address the elements of the logbook requirements. The agency maintains a daily log book (Note Active tablet) to document general program operations. The top of each page is dated electronically to maintain an accurate chronological record of events. Important or critical information is highlighted. All major incidents are highlighted appropriately (i.e. intakes and discharges in blue, notification of parents in, important items in pink, very important items in yellow). All entries in the log require that staff sign at the end of each entry. The log book includes general and specific resident behavioral information, any planned intakes/discharges, and other critical residential care issues. All entries in the professional log must include the date and time, indicating AM or PM; a clear, concise statement of what, where, when, who, and how, and must be initialed by the staff member making the entry.

All staff is to utilize this log for sign-in, sign-out, and passing of keys. This is the individual staff member's responsibility. All staff is to read the log at the beginning of their shift. Since the log is considered a legal document, if any corrections need to be made; one line should be drawn through the entry, "void" written by the error and the correction made. The staff person must sign the correction. If for any reason the electronic log book is not available, a paper log book is used to document required entries. Those entries are then transferred to the electronic log book as soon as it is available, noting that the information was transferred from book format to electronic format.

The agency maintains a daily electronic log book to document general program and operational information. The top of each page is dated to maintain an accurate chronological record of events. All entries must contain either AM or PM along with the hour and minute to indicate the time of day. Intakes and discharges will be highlighted in blue, parent/guardian notifications and attempts in green, important items are highlighted in pink, and very important items are highlighted in yellow. All entries require a signature or initials of staff making the entry.

Staff members must log their time in and out individually along with the documentation of passing keys on to another staff member. Log book is electronic with each paged marked with the date and day of the week at the top of each page. Entries are made with times including AM and PM with staff initial or signature of the staff making the entry.

Late entries are documented and highlighted.

The program has a process in place to document daily activities, events, and other major occurrences except there is lack of evidence that supervisors and all staff review the logbook for the previous two shifts.

Exception:

There is lack of evidence that supervisors and all staff review the logbook for the previous two shifts.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy that addresses behavior management strategies. The program behavior management system is designed to gain compliance with the program as well as enhance the coping skills of the youth. The program has a detailed description of the behavior management system and the behavior management strategies that are to be utilized. Consequences are to be applied logically and consistently. All staff is to be trained in utilizing the behavior management system and the theories behind the behavior management systems practices. Supervisors are trained to monitor the use of behavioral interventions. The behavior management system is designed to be administered in the least restrictive manner and contains a wide variety of positive incentives.

The Behavior Management System (BMS) at the agency is described in the procedure as a Behavior Management Motivation System and is explained in the youth handbook as a Motivation System. The system has three system levels (assessment system, daily system, and achievement system) and two subsystem levels (straight fine and time-based) to address serious, inappropriate behaviors. The BMS provides points for positive behaviors and a reduction in points for negative behaviors. When points are reduced there are opportunities to earn back half of the lost points.

All staff is trained in the BMS and participates in refresher training. Staff performance evaluations address the staff member's use of the BMS and suggestions for improvements in administering the BMS in the most effective manner. The BMS is designed to never deny youth their basic rights including: sleep, meals, clothing, health services, education, exercise, correspondence, and contact with parents/guardians or other protected services such as an attorney or clergy member.

During the first 1-3 days at the shelter, youth are placed on the Assessment System. During the time on the Assessment System, youth are observed by staff members and target skills the youth needs to work on are determined based on observed behaviors and interactions. After the assessment phase is completed, youth are automatically moved to the Daily System. While on the Daily System youth work towards improving and adhering to four target skills.

Points earned each day on the Daily System are used to buy privileges the following day. Each youth has a balance sheet of daily points, which is maintained in a centralized log accessible to direct care and supervisory staff. Daily point sheets for previous days are also maintained in the log along with the balance sheet. Once a youth has mastered the Daily System target skills they are able to move to the Achievement System, which includes no longer needing to carry a point sheet at all times and the ability to earn extra privileges.

Should inappropriate behavior occur, the staff member on duty addresses the behavior, discusses the appropriate behavior and completes a role play of utilizing the appropriate behavior? The direct care staff will then address the inappropriate behavior and target skills again at a later time to reinforce the appropriate behavior and offer the youth an opportunity to earn up to half of their points back by completing the role play with the appropriate use of skills. An interview was conducted with the direct care staff supervisor and she was able to articulate how the BMS was to be administered and an overall understanding of the system.

A random selection of five staff training files of six staff training files indicated all six staff received initial BMS training. The management training log indicates all staff has received initial training in the system as well as dates for refresher training annually. The BMS specifically states that the youth are not to be denied any basic rights and that physical punishment in any form is unacceptable. The BMS training curriculum was reviewed. The training reflected the policy and procedure for administration as well as detailed point administration gains and losses.

Management staff addresses use of the behavior management system during employee training annually. Although the training curriculum does not reference specific point allotments except for reductions, interviews and reviews of point cards indicated that staff has a standardized system for the administration of positive points.

Youth may earn 500-1500 points for positive behaviors in the shelter and up to 3,000 points for positive behaviors on an outing. Reviews of point cards and the system used to address negative behaviors or a lack of using the appropriate target skills indicate an overall positive manner for addressing negative behaviors through teaching and role playing the positive subset of skills associated with the negative behavior. Rewards points are given for pro-social skills that are observed regardless of the identified target skills, which reinforce appropriate social behaviors. Rules and Consequences are clearly explained in the youth handbook which is provided to the youth at intake.

There are no exceptions noted for this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedure in place for this indicator. It was last reviewed on September 29, 2017. Staffing is provided to ensure the safety and security of the youth and staff. The program maintains minimum staffing ratios as required by Florida Administrative Code and contract: One staff to six youth during a wake hours and community activities; one staff to every twelve youth during the sleep period. There is usually at least one staff on duty of the same gender as the youth. There has been times when there was not the same gender staff as client. Overnight shifts must always provide a minimum of two staff present. The staff schedule is provided to staff or posted in a place visible to staff. There is a hold over or overtime rotation roster which includes the home telephone numbers of staff that may be accessed when additional coverage is needed. Staff observe youth at least every ten minutes while they are in their sleeping room, either during the sleep period or at other times, such as illness. The agency practice is only to have females complete bed checks.

The staff schedule is posted in the staff office which is visible to staff and identifies the days/shifts schedule. A review of the staff schedule from 3/26/2017 to present included both male and female staff on shift and maintains two staff at night. The shelter maintains a staff list in the front of the logbook with telephone numbers.

Documentation of bed checks was visible in the logbook. The bed checks were conducted every eight to ten minutes. This was also confirmed by reviewing video surveillance of random nights, from the past thirty days, prior to the review. The overnight staff also does a summary of overall status count of how many youth and which program the youth is in.

A review of the agency's efforts towards securing staff of both male and female genders was reviewed on site. Interviews with the regional director and program manager report that the agency has been conducting on going recruiting through advertisement and major employment channels and online job vacancy website. However, these efforts have not resulted in the agency securing consistent staffing for males on work shifts. The agency does not have a consistent male staff member across work shifts as required per the Florida Network Policy. The agency is required to have representation of each gender due to the probability of serving a child from either gender at any time. Male staff coverage is primarily not consistent on first work shift during Monday - Friday business days. In general, securing male staff at this site is an on-going issue.

It is important to note Hope House has been in the process of hiring additional staff but applicants have not passed the drug test, or the back ground screening. Several new staff have begun their initial training and within a few shifts, have decided this kind of work was not for them.

Hope House is now using “Indeed”, an internet based employment site while at the same time their LSF Human Resources Team re-post the job openings, and they now have a decent number of applicants. They currently have two applicants that have completed their New Hire Paperwork, and are working on their first 21 hours of training, required before they can be with the clients. That will soon be finished and they will be on the floor, ready for On the Job training. In addition, two more people are scheduled to complete their New Hire Paperwork within the next week.

Exception:

Due to staff coverage there are several times per month in which there is not a male and female staff on duty in which the policy states there is always at least one staff on duty of the same gender as the youth. If the program accepts both males and females, there should always be both a male and a female staff present, including the overnight or sleep period.

3.07 Special Populations

Satisfactory
 Limited
 Failed

Rating Narrative

Agency has a policy on Special populations. The program has a policy called LSF-NW Special Populations. The policy contains and addresses the general requirements of this indicator. Items in this section were not applicable or not available for review.

There are no exceptions noted for this indicator.

3.08 Video Surveillance System

Satisfactory
 Limited
 Failed

Rating Narrative

Lutheran Services Florida has a policy that addresses the requirement for operational video camera surveillance systems in their youth shelter. LSF camera policy was last reviewed on September 29, 2017. This policy was reviewed and approved by the agency's Regional Director. A review of the policy indicates that it meets the general requirements of the video camera surveillance system indicator.

LSF’s policy on camera surveillance requires the youth shelter staff to constantly monitor the residence at all times during their shelter stay. LSF has a shelter video surveillance system that is required to be in operation 24 hours a day, seven days a week to monitor and capture recording of happenings continuously to ensure the safety of all youth, staff, and visitors while guaranteeing personnel accountability. The agency utilizes the video system to assist as a deterrent means for any misconduct and to ensure that any allegations of incidents are identified through recorded visual means. The policy requires a video surveillance camera system to capture and retain video photographic images for storage purposes for a minimum of 30 days.

The agency has limited access to video camera footage and supervisors are required to review video once every 14 days and/or sooner and document reviews in the program logbook. Reviews by supervisors are required to include a random review and sample of overnight work shift activity. The agency must also post visual notice to visitors, staff and residents that video camera surveillance systems are in use in the shelter facility. Video camera surveillance systems are to be placed in general areas, and not in areas including bathrooms and or sleeping areas.

Hope House has a video camera surveillance service system that operates 24 hours a day, seven days a week. The reviewer onsite observed the camera in operation and it was working properly as of the date of this onsite review. The camera system includes a total of 16 separate camera views of appropriate areas

related and recording is ongoing within the interior and also exterior of the building. Specifically, these cameras are positioned at the entrance, rear-facing of the building, side-facing of the building, and front-facing of the building. The entrance is also under surveillance, as well as the day room, youth care workstation, kitchen and the lobby areas.

Exceptions:

The agency does not have a list of authorized personnel who are permitted to access the video surveillance systems as required.

Agency does not have a process to address official video request from third parties for audit, investigation or management review purposes.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The LSF-NW agency has detailed policies and procedures related to the screening, health admission screening, classification, assessment and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. All youth receive an initial assessment to determine the youth's risks, needs and issues.

All staff members are trained on risk screening methods that immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health (acute and chronic), or security risk factors. Once risks are identified through the screening and assessment process, residents are placed on the appropriate supervision level or referred out to other local mental health facilities as needed. Depending on the risk identified, the residents are placed on the applicable alert status. The agency ensures that measures are taken to maintain a safe and secure placement and supervision are provided by direct care staff during the resident's shelter stay. The agency maintains a program log, general alert system, pass down/shift exchange forms, and other notification systems. Youth admitted to the shelter with prescribed medications are also provided their medications during their shelter stay.

Staff members participate and conduct emergency drills on a routine basis. The agency's staff receives orientation and annual training courses that include Universal Precautions, Safety and General Program Risk Management training, CPR and First Aid. In addition, the agency does have a certified Managing Aggressive Behavior (MAB) Trainer in the organization.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a detailed policy on Healthcare Admission Screening. A review of the agency's current policy was conducted on site. This review of the policy's content resulted in the monitor determining that Lutheran Services Florida (LSF) Health Care Admission Screening policy contains comprehensive detail on the work required to meet the general requirements for an effective Health Admission Screening to be performed. The policy was last reviewed and approved by the Northwest Regional Director on September 29, 2017.

Lutheran Services Florida procedures are developed to address the ability to ensure that the screening of acute health conditions is in place. The procedures outline the method used to screen newly admitted residents for a broad array of medical conditions. The agency's healthcare admission screening procedures requires that direct care and other trained staff conduct healthcare screenings on 100% of all clients. The health screening process is required to be verified by the registered nurse when on duty or upon return. The agency uses multiple forms to complete this process.

The agency practice for the health screening process is initiated during the intake process. The CINS/FINS Intake Form is one of the primary tools utilized by the program to screen for the current status of health of clients and any acute health conditions. Further, the screening form asks about the past, recent or current use of medications, existing medical conditions, allergies, recent injuries or illnesses, presence of pain or other physical distress, observations for evidence of illness, injury, physical distress, difficulty moving, etc. and observation for presence of scars, tattoos, or other skin markings. Other conditions screened for includes diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries which occurred during the previous two (2) weeks, chronic bronchitis and other health issues. The agency's secondary health screening form addresses all elements of the indicator.

A review of three (3) open and 3 closed residential client files reviewed contained documentation of the CINS/FINS Intake form that was completed by direct care residential and screening staff. A review of each

of the 6 health screening documents revealed that the agency is capturing health screening findings according to the requirements of this indicator. The review of all files found that the agency screens for current medications and existing medical conditions. The agency has a separate form that documents the observation of markings including scars, marks or tattoos. All 6 files reviewed contained the required forms. The agency has an active medical or injury referral process, a method to contact parents and follow-up medical care on an as needed basis when applicable.

There are no exceptions noted for this indicator.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency has a suicide assessment and prevention policy. The current policy includes the requirements that the agency have a written detailed policy that addresses the suicide prevention process. In general, the policy requires that all residential and non-residential clients meeting CINS/FINS eligibility services and admitted to the program be screened for suicide risks as part of the initial intake and screening process. The policy states that the youth awaiting assessment by a licensed professional are placed on constant sight-and-sound supervision. This policy review results in the opinion of the monitor that this Suicide Prevention policy meets the general requirements of the indicator. The policy was last reviewed and approved by the Northwest Regional Director on September 29, 2017.

The agency's suicide assessment procedures require that a multi-step screening process be followed by the shelter staff. The initial screening process requires that if a youth indicates an initial positive for suicide risks, the direct care staff are required to place the resident on elevated supervision status. Following this step, the procedures then require that staff conduct observation checks at a minimum of every 30 minutes or less until an assessment is completed. A licensed professional or a non-licensed professional under the supervision of a licensed clinician must then complete an assessment on the youth on supervision within 24 hours or less. The agency has an on-call schedule for all master level counselors.

The agency uses an Evaluation of Imminent Danger of Suicide (EIDS) tool to assess the level of suicide risk. A low rating of risks results in the youth being placed on low risk status and placed on general supervision status. If a youth is deemed to be in question of potentially committing a self-harm act or suicidal behavior, the youth is to remain being on elevated supervisor one-to-one supervision. If the youth requires a Baker Act determination, the agency contacts law enforcement. The agency uses the EIDS and consults the licensed clinician. Following the assessment of suicide risk, the youth supervision status can stay the same or only be removed from the status by the licensed clinician. All staff in the residential shelter must maintain one-to-one supervision or constant supervision and document observation checks on the status of the resident every 30 minutes or less interval on observation log sheets.

All direct care staff are trained to complete a CINS/FINS intake and a EIDS assessment form. A review of six (6) client files found that all 6 files contained evidence of the CINS/FINS intake form and the Evaluation of Imminent Danger of Suicide (EIDS) from. The suicide risk screening forms and the EIDS assessment documents are present in all 6 client files. A total 5 out of 6 client files are completed as required. Assessment forms are completed in all applicable cases. One case has an assessment that has errors in the calculation results that determine whether to place the youth on high or low elevation status. This case was corrected by the master's level counselor during the secondary review of the EIDS. All client files possessed evidence of observation logs documenting the times, behavior status and person conducting the check. All observation checks reflect documentation of accurate and complete counts in intervals of 30 mins or less. All applicable client cases were placed on the appropriate level of supervision consistent with the suicide risk assessment result. All cases had evidence that the client is placed on sight and sound supervision until they were assessed by a licensed clinician or a non-licensed staff member under the direct supervision of a licensed professional. All cases had documented evidence that the supervision level of the client placed on supervision was not changed/reduced until the licensed clinician or non-

licensed mental health professional under the supervision completed a further assessment to determine the status.

Exception:

The agency uses an Evaluation of Imminent Danger of Suicide (EIDS) tool to assess the level of suicide risk on all youth admitted to the residential shelter. One client case was missing evidence of a completed assessment form.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a general medication policy. The medication policy is current. Policy includes provisions that address the distribution of medications, storage of medications, access, inventory, disposal and general operations in accordance to DJJ and Florida Network policies outlined in their respective manuals. In general the policy addresses major areas related to medication procedures and relative performance and safety protocols for the safe handling and distribution to residents during their shelter stay. The policy was last reviewed and approved by the Regional Director on September 29, 2017.

The agency is required to screen for general health conditions and assess the medication needs of all residents upon admission to the program. Procedures include protocols for storing medication in the Pyxis automated medication cart; training delivered by the Registered Nurse (RN) to all staff; storage protocols for controlled and non-controlled inventory standards; distribution of medication in accordance to documentation practices and distribution to each resident that requires medication; and notification of medications prior to a resident running out of medications. The agency has specific practice steps for documenting and reporting medication errors as required by agency policy. The agency also has specific disposal procedures to ensure that medications are handled in accordance with agency standards.

The agency manages prescription medications brought to the facility by the resident and or those over the counter medications in the Pyxis MedStation 4000 automated medication cabinet. The agency hired a full-time Registered Nurse (RN) in April 2017. The RN's major responsibility involves the oversight and administration and distribution of medications in accordance with DJJ and Florida Network standards as outlined in their respective manuals. The RN works a total of twenty (20) hours per week. The RN primarily works Monday through Friday. The registered nurse at the Hope House location operates by the same standards and protocols as the RN that oversees the Currie House shelter location.

The agency's RN performs all medication duties during her normal work shift. The RN works a few hours per day on the first shift Monday-Friday. The RN is also available to all staff for consultation on-call after hours when she is not on duty. The nurse also conducts Health admission screenings for all residents when they are admitted. The agency's program manager monitors all first aid kits to ensure that they are fully stocked. The agency maintains a total of 3 to 5 first aid kits. There are first aid kits maintained in each transportation van.

The nurse reviews all medication distribution logs (MDL) when on duty. The nurse assesses all MDLs to ensure accuracy and completion of the medication documentation process. If an error is detected, the registered nurse documents it accordingly. When serious errors are detected the nurse conducts a root cause assessment and submits a brief written summary via email to the manager and documents it in the pass down log immediately. Minor errors and issues are recorded and reviewed in future training.

At the time of this review, discrepancies are being reviewed and closed by the registered nurse and the residential supervisor. Recently, the agency reviewed and will change the procedure and will soon require staff that made the error to clear discrepancies prior to the close of their work shift. All applicable medication errors by the program are required to be reported to the DJJ CCC. When an error is documented, the agency has a process that includes a root cause assessment and personnel action taken

to document the incident. The registered nurse also provides coaching and re-training to reduce the reoccurrence of the error. The registered nurse assesses and schedules remedial, testing and supervises and oversees all re-training.

The registered nurse oversees all training of both super users and regular users authorized to utilize the Pyxis MedStation 4000 automated medication cabinet. As of the date of this review, the agency had five (5) Super Users. The agency has 5 regular Pyxis MedStation users. The agency is storing oral medications separate from injectable and topical medications inside the Pyxis Cabinet. At the time of this program review, the Pyxis MedStation is operational and the registered nurse conducted an inventory exercise in drawers one and two with the monitor while on site. The registered nurse also accesses the Pyxis MedStation knowledge Portal to review medication distribution practice on a daily, weekly and monthly basis.

The agency uses a medication distribution binder that houses all the individual paper medication logs of each resident on medication. The medication distribution sections for each resident includes a format sheet, a blank MDL form with appropriate sections including the client's medication type, dosage instructions, frequency, and signature. The agency has a compact refrigerator specifically dedicated for medication that must be refrigerated. The review had staff open the refrigerator and observed a thermometer temperature of 36 degrees.

The agency maintains sharps. The agency does not accept residents that require syringes with specific dosage requirement that they must maintain and receive during their shelter stay. However, the agency does accept residents that have EpiPens for specific allergies on a case-by-case basis. The agency maintains sharps that include scissors, razors, tweezers, nail clippers, make-up pencil sharpen and nail file. A review of the sharps inventory count binder revealed that sharps are counted one time per week. A review of the binder revealed that the provider maintains over-the-counter medications that include Ibuprofen 200mg, Pink Bismuth-Stomach Relief, Equate Stomach Relief, Jr. Acetaminophen, and Triple Antibiotic Ointment. All OTC medication counts are documented on a weekly basis from April 4, 2017 to October 2, 2017. The reviewer verified these counts by reviewing weekly OTC Inventory Log.

The agency conducts shift counts on medication for controlled narcotics every work shift 3 times a day. Non-controlled medications are counted when distributed and at least once per week.

The agency has a process that requires staff to alert the parent or guardian when a resident has 5 to 7 doses of their medication remaining.

Medication must be disposed when left behind by a client after discharge for more than 90 days. Disposal requires two (2) individuals to verify and confirm that the medication is disposed of properly. Medication is destroyed by the registered nurse and a witness. The medication to be disposed of is stored in a medication bottle and water is added to dissolve the medication. The medication cap is placed back on the bottle and then the bottle is sealed and discarded in the wasted bin. Additionally, the agency has 2 biohazard containers located on site in the youth care specialist office. All sharps are locked in a metal 4 drawer cabinet in the Youth Care Specialist office.

It is noteworthy to mention the agency had an medication error that has been reported and accepted by the DJJ CCC. In the last 6 Months, the agency has reported a total one incident (20187-03459 Complaint Against Staff). This incident occurred on July 15, 2017 and was reported on the same day. A review of this incident found that a staff person forgot to distribute prescription medication to a resident at 9:00pm as required. This missed medication session was discovered and reported by another staff person. At the time of this onsite program review, the agency did have recorded documentation of supervisor review and documentation of corrective follow up by management. Agency provided supervision and evidence of a remedial quiz that was completed by the staff involved in committing the incident.

There are no exceptions noted for this indicator.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy called Medical/Mental Health Alert Process. This policy was last reviewed and signed by the LSF-NW Regional Director on September 29, 2017. The agency policy includes measures to ensure the provision of emergency medical and dental care. The policy addresses the current status of the youth's condition, physical activity restrictions, allergies, common side effects of prescribed medications, foods, and medication contraindication. Other pertinent treatment information is communicated to all staff through a designated alert system. The content in this policy meets the general requirements of this indicator.

The agency procedure required all YCS, counselors and supervisors are required to complete a medical and mental health and behavior screening. Youth Care Specialist staff are required to document and inform nurses of clients with medical issues that need further assessment. Staff must ensure effective communication of medical issues through the health screening, professional log, case progress notes and other relative forms of program communication.

The agency requires that critical care information be communicated to all staff by utilizing a couple of communication methods. The agency uses communication methods called a pass-down information log and a dry erase board on which general client information is listed. The agency requires that residential staff utilize a system of codes to protect client confidentiality. The agency utilizes files to designate the specific type of client that includes different color folders for Families First Network-FFN and for CINS/FINS Staff Secure or Court-Ordered Clients; and a blue folder for all other CINS/FINS clients including DV Respite, Probation Respite, Staff Secure and Minor Sex Trafficking Victim.

The agency also requires that staff use a color-coded dot system that uses an orange dot for Sight and Sound clients; a red dot to indicate High Risk clients; a green dot for youth on medication; and a blue dot for client admitted to the shelter for a Domestic Violence Respite (DVR). The pass-down log is a 1 page document that includes type of client; medications and allergies; side effects; mental health (HR High Risk, LR Low Risk, CO Court Order) Appointments; Corrective Actions; Chronic Complaints; Discharge Plans; and Visits and Outings. Additional codes used by the agency include Sight and Sound-SS; Run Risk-RR; and No Know Allergies-NKA.

A total of six (6) files were randomly selected to verify the agency's adherence to the requirements of this indicator. Of these files reviewed, three (3) were open cases and 3 were closed. All cases were appropriately marked for the corresponding documented alerts across the client files.

The agency also uses a pass down log. This one sheet form tracks the condition and status of each child on a daily basis. All cases were appropriately marked for the corresponding documented alerts by verifying the content documented in the agency's Pass-Down log. All cases were appropriately marked for the corresponding documented alerts by verifying general non-confidential information documented on the agency general alert board located in the Youth Care Specialist office. In addition, a review of the logbook verifies the conditions and status of all 3 open cases.

There are no exceptions noted for this indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has an Episodic Event and Emergency Drill policy. The policy was last reviewed and approved by the Northwest Regional Director on September 29, 2017. The policy includes reference to procedures to ensure that agency staff execute the provision of emergency medical and dental care as required. A review of the agency's two-page policy verifies that the policy adheres to and meets the general requirements of the indicator.

The agency's procedures involve a process to address how the agency will respond to emergencies that require off-site emergency services; notifying parents/guardians; reporting all reportable incidents; documentation events in a daily log; verification of medical clearance status upon return and any required medical follow up care. The agency must also have the required emergency equipment that includes first aid kits, knife for life, breathing barriers, fire extinguishers and blood borne pathogen kits in the facility.

The reviewer of the indicator found that the agency maintains a binder of emergency event activity called the Episodic Care log. The log is a 3-ring binder that utilizes an Episodic Care and Drill Log. The Log captures Date; Time; Shift; Duration; Number of staff; Number of clients; and Number of Admin Staff and Guests; Comments; and Event. The binder maintains all mock exercises and real emergency events.

The binder review includes observation of activities that have taken place since March 2017 to present. The agency has a goal of practicing 1 Care event, 1 Disaster event and 3 fire drills (one per 1 shift per month). The agency has completed a total of fourteen (14) documented mock episodic events since April 2017. Most events were conducted on the 1st and 2nd shift. A total of five (5) events were documented on the third shift. Events include fire/smoke; administration of first aid; bomb threat; property damage; law enforcement call; minor flood; unconscious person; hazardous waste spill and thunder storm/tornado event.

The agency had a 2 medical related incident events that were called into the DJJ CCC and accepted. The first event involved a youth that was suffering from abdominal pain that occurred on the August 17, 2017. This youth was transported by his Mother to the Hospital, assessed and released. Mother returned the youth to the shelter with a nausea medication. The second incident involved a youth that was Baker Acted to a local mental health facility. Youth was Baker Act prior to completing their Intake session.

There are no exceptions noted for this indicator.