



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

Review of LSF NW- Hope House

on 09/14/2018

## 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	Limited
1.07 Outreach Services	Satisfactory

Percent of indicators rated Satisfactory:85.71%  
Percent of indicators rated Limited:14.29%  
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	Limited
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity/Expression	Satisfactory

Percent of indicators rated Satisfactory:87.50%  
Percent of indicators rated Limited:12.50%  
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:89.29%  
Percent of indicators rated Limited:10.71%  
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

Ashley Davies, Lead Reviewer/Consultant, Forefront LLC

Pamela Washington, Team Leader, Arnette House

Jason Ishley, Non-Residential Clinical Director, CCYS

Tiffany Williams, Director of QA and Data, YCC

Warren Garrison, Regional Monitor, DJJ

**Persons Interviewed**

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

**Documents Reviewed**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports                        | <input checked="" type="checkbox"/> Fire Prevention Plan             | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records        | <input type="checkbox"/> Visitation Logs                       |
| <input checked="" type="checkbox"/> CCC Reports                       | <input checked="" type="checkbox"/> Key Control Log                  | <input checked="" type="checkbox"/> Youth Handbook             |
| <input checked="" type="checkbox"/> Logbooks                          | <input checked="" type="checkbox"/> Fire Drill Log                   | 7 # Health Records   |
| <input checked="" type="checkbox"/> Continuity of Operation Plan      | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 # MH/SA Records  |
| <input type="checkbox"/> Contract Monitoring Reports                  | <input checked="" type="checkbox"/> Table of Organization            | 7 # Personnel Records  |
| <input type="checkbox"/> Contract Scope of Services                   | <input checked="" type="checkbox"/> Precautionary Observation Logs   | 6 # Training Records   |
| <input checked="" type="checkbox"/> Egress Plans                      | <input checked="" type="checkbox"/> Program Schedules                | 4 # Youth Records (Closed)                                     |
| <input checked="" type="checkbox"/> Fire Inspection Report            | <input type="checkbox"/> Telephone Logs                              | 4 # Youth Records (Open)                                       |
| <input checked="" type="checkbox"/> Exposure Control Plan             | <input type="checkbox"/> Supplemental Contracts                      | 0 # Other  |

**Surveys**

4 Youth                      4 Direct Care Staff

**Observations During Review**

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

**Comments**

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

Rating Narrative

## **Strengths and Innovative Approaches**

### Rating Narrative

The agency's community food program has grown tremendously. They are able to provide food and other daily needs for about 500 households each month.

The agency held their annual hurricane mock drill in June, it was called Hurricane Martin. They battened down the hatches and evacuated the shelters. This was their 10th annual hurricane drill. The HOPE House teams, Red (Preparation), Green (Evacuation) and Blue (Recovery) did an amazing job. The shelter youth also participate in the week long chain of events and learned the importance of being ready for a disaster.

The shelter continues to have their monthly Cultural Celebrations. The youth learn about a different culture each month and the celebration culminates with a dinner utilizing recipes from that country and when available a speaker from that country. They have also had a football season kickoff party, Thanksgiving Day Feast, Christmas and New Year's celebrations, Super Bowl party, 4th of July fireworks, National Ice Cream Day, and several birthday celebrations.

The youth have had the opportunity to learn a variety of skills this year. They have learned to do comparison shopping, baking, cooking, gardening, organization, and many other things. Comparison shopping covers a range of goods from groceries to clothing to setting up a new apartment. The shelter has some musical instruments available that the youth can enjoy playing.

There have been several speakers this year talking to the youth about a variety of subjects including a speaker from the Army (recruiting office), local firefighters, and weekly Bible study. They also toured a model mobile home, a fire station and the FAMU Pharmacy College, and visited the highest point in Florida. Dozer, a therapy dog, visits the youth monthly.

The youth have learned to make putty, stress balls, kites, crochet, painting, and a variety of craft activities. They have done some sewing, yard work, cleaning the vans, creative writing, and, made strawberry jam. They have also learned some self-care skills such as foot care, pedicures, and hygiene basics for adolescents.

The United Way Day of Caring volunteers will be coming to the shelter the week following the on-site review to re-mulch the front yard and pressure wash the concrete around the building.

The shelter was selected last year to be one of the counties to provide Intensive Case Management Services.

LSF Shelters have begun using the Predictive Index in the hiring process for YCS. It provides a profile of applicants to exhibit the characteristics identified as important to the position.

They have applied for a grant to purchase new vans and reconfigure the shed to house the food program.

## 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 Manager; Youth Care Specialists (YCS); a Registered Nurse (RN) and Administrative staff.

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

The agency has a policy in place for Background Screening of Employees and Volunteers. The policy was last reviewed and updated on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

LSF-NW conducts Live Scan Background Screening on all potential employees and volunteers. The background screening must be completed prior to any offer of employment, granting of volunteer status, and/or before any direct contact or participation in agency activities may occur. During completion of the new hire packet, each employee must sign that they are responsible for reporting any arrest or notice to appear for a criminal charge to his/her supervisor/manager within twenty-four hours of the arrest or receipt of the notice to appear. All forms are retained in each employee's confidential personnel file. A rescreening of each active employee is completed every five years after the date of initial screening. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually and sent to the DJJ Background Screening Unit by January 31st of each year.

There was one staff hired, since the last on-site review, working at the shelter. There was documentation an eligible background screening was received prior to the staff's hire date. There was one staff member who was due for a five-year re-screening during this review cycle. There was documentation the re-screening was completed; however, it was completed approximately three months after the staff's initial hire date. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the DJJ Background Screening Unit on January 3, 2018.

The agency has began using The Predictive Index as a pre-employment assessment. After a person fills out on application on-line they are then instructed to complete an on-line pre-employment assessment. The Predictive Index quantifies people's behavioral drives in the workplace in four areas that give insight about how someone will behave at work. They are called the Four Factors and include: Dominance, Extraversion, Patience, and Formality. The assessment gives the interviewer strengths, cautions, and self-coaching tips, in each of the four areas above, for the interviewee. This helps they agency better process job applications and individualize interview questions for each interviewee. The agency has used the assessment on a few job applicants already; however, they are still in the training and implementation phase. The staff are still learning about the different reports that can be run from the assessment and how to effectively use all the information gathered to find the best possible candidates for the job vacancies.

There were no exceptions to this indicator.

### 1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy in place for Provision of an Abuse Free Environment. The policy was last reviewed and updated on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

The program provides an environment in which youth, staff, and others feels safe, secure, and not threatened by any form of abuse or harassment.

1. Program staff adheres to code of conduct that prohibits the use of physical abuse, profanity, threats, or intimidation. Youth are not deprived of basic needs, such as food, clothing, shelter, medical care, and security.

2. Any person who knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for child's welfare as defined by Florida Statute, or that a child is in need of supervision and care and has no parent, legal custodian, or responsible adult relative immediately known and available to provide supervision and care, reports such knowledge or suspicion to the Florida Abuse Hotline.

3. The program must have an accessible and responsive grievance process for youth to provide feedback and address complaints. This process should allow youth to grieve actions of staff and conditions or circumstances related to the violation or denial of basic rights. Direct care workers shall not handle the complaint/grievance document unless assistance requested by youth.

4. Management take immediate action to address incidents of physical and/or psychological abuse, verbal intimidation, use of profanity, and/or excessive use of force.

The program has established appropriate behavioral expectations (Code of Conduct) for staff that include identifiable standards, clear values, and concepts that reinforce programmatic goals and objectives. During the new hire process, employees sign various forms stating that they have read these behavioral expectations and agree to comply with them. These forms are maintained in the employee's personnel file.

There were seven personnel training records 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 have access to a majority of the day. The room is also utilized by the counselors at the program.

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 had been no grievances filed in the last six months.

All four youth responding to the survey reported they know the Abuse Hotline is available for them to report abuse if needed, they all know where the number is located, and all reported they have never been stopped from attempting to make a call to the hotline. All youth reported that staff are respectful when speaking to youth; however, they have occasionally heard a staff member use inappropriate language.

All three staff surveyed reported they have been trained on the Abuse Hotline procedures and they have never heard another staff member deny a youth access to the Abuse Hotline. All three staff reported they have never heard another staff member using threats, humiliation, or intimidation when interacting with the youth.

At the time of the review, the locked grievance box used for youth to submit their grievances was broken. It was reported a former youth had ripped the box off the wall and damaged the box. The shelter was currently waiting on the youth's parent to provide the funds to replace the box. The shelter had alternative procedures in place until the box was replaced.

Further to an interview with staff, the lead reviewer was able to verify that youth are able to turn the grievance into a supervisor or administrative staff of their choice until the box is fixed.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy in place for Incident Reporting. The policy was last reviewed and updated on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

The policy and procedures comply with the Department of Juvenile Justice (DJJ) incident reporting guidelines and Florida's Administrative Code. Procedures include contacting the Central Communication Center (CCC) within two hours, notifications, incident report forms, documentation, entries into NoteActive, and faxing all CCC's reported, to the Florida Network.

A total of twelve incidents were reported to the CCC within the last six months. Out of the twelve, six were labeled "medical incident", five were labeled "program disruption", and one was labeled "compliant against staff".

All twelve incidents were reported to the CCC within the two-hour time frame. An incident report was found for ten of the twelve incidents, which documented a description of the incident, all notifications made, and reviews by all applicable parties. Special instructions and any follow-up documentation needed by the CCC was found for each of the twelve incidents. Each incident was documented in NoteActive.

It should be noted that there were two out of the twelve incidents reviewed that did not have an incident report completed by the program that documented a description of the incident, notifications, and reviews.

### 1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Training Requirements. The policy was last reviewed and updated on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions. All direct care CINS/FINS staff (full-time, part-time, and on-call) shall have a minimum of 80 hours of training for the first full year of employment. Direct care staff, in residential programs licensed by DCF, are required to have 40 hours of training per year after the first year. The policy includes all of the listed 120 day training requirements, first year of employment requirements, and DJJ-SkillPro Learning Management System requirements.

The program maintains an individual training file for each staff, which includes an Annual Employee Hours tracking form and related documentation such: as certificates, sign-in sheets, and agendas for each training attended.

A total of six training files were reviewed. Of the six files reviewed, four were employed by the program for longer than one year and the remaining two were reviewed for training completed during the first 120 days of employment. There were no staff training files applicable for training completed during the first year of employment.

Both training files reviewed for the 120 day requirement documented all required training's had been completed in the first 120 days of employment.

All four staff reviewed for annual training requirements documented at least forty hours of training for the last completed training cycle. All required training's were documented with the exception of some required DJJ Skill Pro training's.

Additional to note, three out four files reviewed for annual training requirements were missing between one and three required training's in DJJ Skill Pro.

**1.05 Analyzing and Reporting Information**

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Analyzing and Reporting Information. The policy was last reviewed and updated on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

The agency has developed and implemented procedures for the regular review of case records, incidents, accidents, grievances, consumer satisfaction data, outcome data, and NetMIS data reports. Continuous Quality Improvement (CQI) teams have representatives from the various programs in LSF-NW and are responsible for reviewing and reporting information and data to the Management Teams, their individual programs, and the statewide Quality Services Manager (QSM). Weekly and monthly reports to the statewide QSM are made for all LSF programs. Identified strength and weaknesses within each program are discussed at monthly staff meetings and corrective action and improvements implemented. Documentation is forwarded to the QSM for review along with any recommendations for changes to procedures.

The program collects and reviews several sources of information to identify patterns and trends including monthly reviews of NetMIS data reports which is dispersed through the agency via the QSM. The agency has Continuous Quality Improvement (CQI) team members that meet monthly and discuss monthly peer reviews, service satisfaction, and incident reports. The agency maintains meeting minutes and agendas for their monthly improvement processes.

A review of the Case Record Review report submissions since the last compliance review completed in October 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 last two quarters.

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

There were no exceptions to this indicator.

**1.06 Client Transportation**

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Client Transportation. The policy was last reviewed and updated on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

The program has a transportation policy that is implemented by agency approved drivers. The basis of the policy is to avoid situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth. The best practice to prevent such situations is to have a 3rd party present in the vehicle while transporting a client. Drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicles, drivers are documented as having a valid Florida driver's license and covered under company insurance policy, third party members are approved volunteer, intern, agency staff, or other youth, and documentation of vehicle use notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.

Approved agency drivers are documented as having a valid Florida driver's license and are covered under the company insurance policy.

The Transportation Records and the Transportation Log were reviewed assessing the agency's evidence of client transportation. The number of passengers and purpose of travel was documented correctly for each usage.

Exception:

The mileage, time, and staff signature were inconsistently filled in on the Transportation Logs.

In the past six month there have been forty-nine documented single client transports. Out of those forty-nine transports only eighteen documented prior supervisory approval for the transport.

### 1.07 Outreach Services

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy in place for Outreach Services. The policy was last reviewed and updated on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

The agency has planned a Outreach program. This component of service is supervised by the Regional Director and performed by an outreach coordinator or outreach specialist assigned to this specific function. The Regional Director, Clinical Director, Services Managers, and Outreach Team develop annual strategic plans with specific projected prevention outreach goals, objectives, and outcomes. The agency's Prevention/Outreach efforts target at-risk, runaway, and homeless youth and their families as well as the community at large. The prevention strategy focuses on educating youth and families on the dangers of running away, and informing them about community resources available to them in times of crisis. The program informs the community of its services through community presentations and printed materials.

The agency contributes to the implementation of Departmental objectives through participation in local and circuit level meetings. The assigned representatives to these groups will advocate for the effective use of CINS/FINS services and update agency leadership on meeting activities. There is a lead staff member designated to attend local and circuit level meetings convened by the Department of Juvenile Justice.

The program provided documentation of fifteen interagency agreements. 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 a few outreach services since the last annual compliance review; however, these events were not documented. There was documentation the designated person based in Pensacola had attended the quarterly DJJ local and circuit level meetings.

During this review, it was noted and observed that outreach activities performed by shelter staff are not being documented or entered into Netmis.

## Standard 2: Intervention and Case Management

### Overview

#### Rating Narrative

Lutheran Services of Florida Hope House Residential and Non-Residential counseling programs provide CINS/FINS services to youth and families in Walton, Escambia, Santa Rosa, and Okaloosa Counties in Florida. Hope House provides respite care and individual, family, and group services to youth and families in their catchment area. The program maintains relationships with local providers, referral sources, and community partners. Hope House currently has all master's level clinicians supervised by a Licensed Mental Health Counselor. Referrals to residential and non-residential programs are generated from local schools, the Department of Juvenile Justice, the Department of Children and Families, local courts, and community partners.

### 2.01 Screening and Intake

Satisfactory
                         
  Limited
                         
  Failed

#### Rating Narrative

The agency has a policy in place for Screening and Intake. The policy was last reviewed and updated on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

Procedures for this policy are outlined in detail. These include the following: practices ensuring 24-hour access to services during business hours and after-hours; practices for handling on-call situations; approval of youth for residential and non-residential services; acceptance of referrals for each program; screening for eligibility; management of suicide risk identified at intake; completion of intake assessments; and initiation/completion of the Needs Assessment.

There were eight files reviewed, four residential and four non-residential. During the intake process the youth and parent/guardian is made aware of service options, rights and responsibilities, grievance procedures, and possible actions occurring through the CINS/FINS process. In Residential services, this occurs via the CINS/FINS Voluntary Placement Agreement, Grievance Procedure Form, FNYFS Client Informed Consent & Introduction to Services, and CINS/FINS pamphlet. In Non-Residential services, this occurs via the FNYFS Client Informed Consent & Introduction to Services, and CINS/FINS Brochure. In all eight files the forms were signed by the parent/guardian, youth, and intake counselor. All eight files had eligibility screenings completed within seven seven days of the referral.

There were no exceptions to this indicator.

### 2.02 Needs Assessment

Satisfactory
                         
  Limited
                         
  Failed

#### Rating Narrative

A written, up-to-date, policy (2.02) and procedure is in place that outlines their process for initiating and completing the Needs Assessment (NA), and includes elements required by the FL Network's Policy & Procedure manual. The policy was reviewed on 9/5/18 by regional director, Beth Deck.

The policy states the NA is initiated within 24 hours of admission in shelter care, or completed within three face-to-face contacts following intake if in non-residential care. The NA is completed by Bachelor's or Master's level staff and signed by a supervisor. The suicide risk assessment (if needed) is signed and dated by a licensed supervisor or licensed clinical staff.

Procedures for this policy are outlined in detail. These practices include timeframes for initiating/completion NAs both residentially and non-residentially, staff tasked with completion of the NA (master's level clinician), review of NAs by a supervisor, and completion of an EIDS with review by a licensed supervisor. The procedure also outlines, in detail, the components of the NA which include: demographics, reason for referral, mental health/medical/developmental history, educational history, legal history, family history, drug & alcohol history, family dynamics, strengths, etc.

There were four Residential files reviewed, two open and two closed. All four files contained a Needs Assessments (NA) initiated and completed within appropriate time-frames. All NA's were completed by a Bachelor's or Master's level clinician and reviewed by the Clinical Supervisor. Two of the files contained updated NA's due to being in the shelter less than 3 months ago, and were completed in the appropriate time frame and signed by the clinical supervisor. One of the four files indicated an elevated suicide risk screening, but it had not yet been reviewed by the clinical supervisor.

Four Non-Residential files were reviewed (2 open, 2 closed). All NAs were initiated, and completed, within required time frames. In all cases the NA and summary was completed the same day as intake. All NAs were completed by a Master's level clinician. No reviewed files indicated elevated suicide risk.

It was further observed and noted that two closed non-residential files were missing supervisor signatures on the Needs Assessment summary.

### 2.03 Case/Service Plan

Satisfactory
                         
  Limited
                         
  Failed

Rating Narrative

The agency has a policy in place for Case/Service Plan. The policy was last reviewed and updated on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

Procedures are outlined in detail regarding completion of the case/service plan. The plan is developed within seven working days after completion of the assessment, and is developed based upon information gathered during screening, intake, and assessment. It includes the following: identified need(s) and goal(s), type/frequency/location of service(s), person(s) responsible, target date(s) for completion, actual completion date(s), signatures of the youth/parent/counselor/supervisor, and date the plan was initiated. Direct services provided by agency staff include counseling, support to the family, crisis intervention, parenting skills, and shelter services. The procedure requires service plans to be reviewed every 30/60/90 days to assess progress towards agreed-upon goals. A family may be referred to the case staffing committee if they have not been successful in meeting goals outlined on the plan.

There were four Residential files reviewed, two open and two closed. All four files contained a Case Plan that was completed within the required time frames. It should be noted all the Case Plans were completed on the same day as the youth arrived at the shelter. All Case Plans contained required information as it relates to needs, goals, type/frequency/location, persons responsible, target dates, and completion dates. All Case Plans reviewed contained goals that reflected presenting issues identified at the screening and information gathered during the Needs Assessment. All four Case Plans had signatures of the youth, counselor, and supervisor, but three were missing a parent/guardian signature.

There were four Non-Residential files reviewed, two open and two closed. All four files contained a Case Plan that was completed within required time frames, and reflected presenting issues noted on the screening and information gathered in the Needs Assessment. All Case Plans reviewed contained required information in regard to identified needs, goals, type/frequency/location of services, persons responsible, and target dates. All case plan reviews were completed on time, with the exception of one thirty-day review.

Additional to note, there were three out of four Residential Case Plans reviewed that were missing a parent/guardian signature. Additionally, there was no evidence of a verbal review of the plan face-to-face, via phone, or electronically.

In two of the four Non-Residential plans reviewed there were no supervisor signatures on the Case Plans. The same two files did not have completion dates for the goals on the Case Plan.

### 2.04 Case Management and Service Delivery

Satisfactory
                         
  Limited
                         
  Failed

Rating Narrative

The agency has a policy in place for Case Management and Service Delivery. The policy was last reviewed and updated on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

Procedure states each youth is assigned a counselor or case manager that is responsible for following the case and ensuring appropriate delivery of services. These services may include counseling, shelter services, service plan implementation, progress monitoring, referrals to the case staffing committee, external referrals as needed, and case termination with follow-up. Procedure also notes interagency agreements with local community agencies for the purpose of ensuring a variety of services are available to clients.

There were eight files reviewed, four Residential and four Non-Residential. In all the files reviewed, a counselor was assigned to the youth/family. There were SOAP notes, staffing notes, and case summaries that reflected when referrals were being made, as needed. Progress was being monitored by the counselor, and was reflected in SOAP notes and Case Plan reviews. All thirty and sixty day follow-ups were observed in the closed files and completed in appropriate time frames.

There were no exceptions to this indicator.

### 2.05 Counseling Services

Satisfactory
                         
  Limited
                         
  Failed

Rating Narrative

The agency has a policy in place for Counseling Services. The policy was last reviewed and updated on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

The procedure details case coordination, case file organization and confidentiality, client confidentiality, chain of trust, and self-monitoring. Procedure states case files show a direct connection between presenting issues, assessments, case management, case planning, and follow-up. Services may be provided at a variety of sites accessible to families locally when they cannot be provided at the agency's primary location. Procedure states all case files adhere to all laws regarding confidentiality and communication with third parties.

The agency also offers substance abuse education as a programmatic activity. Counselors provide substance abuse awareness and education services to clients. If the assessment indicates a need for more intensive services a referral to a specialized provider is made within five working days of the identified need.

There were eight files reviewed, four Residential and four Non-residential. In all files reviewed the youth's presenting problems were addressed in the Needs Assessment, Case Plan, SOAP notes, and Case Plan reviews. There were SOAP notes were present in all files and youth were being met with regularly. Staffing notes with a supervisor were documented on the contact sheet and occurred on a regular basis. Both programs are providing individual and family counseling as deemed appropriate.

Exception:

A review of the residential Group Log revealed inconsistent documentation of groups occurring five days a week.

A review of the log for the last six months revealed five weeks, during March thru May, with no documentation of groups occurring. It was explained that during these times a prior counselor had personal issues going on that impeded their ability to facilitate groups and/or document when they did occur. It was reported groups did occur during these time frames but there is no documentation supporting this.

In addition, there were five weeks, between July 22nd and September 5th, that did not document five groups occurred during the week. During these time frames it was explained that because there is only one counselor in the shelter who is often responding to crises that is the reason groups were not occurring all five days.

## 2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

### Rating Narrative

The agency has a policy in place for Adjudication/Petition Process. The policy was last reviewed and updated on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

Procedures for this indicator are outlined in great detail. A Case Staffing Committee (CSC) is called to review the case of any youth or family that may not be in agreement with services or treatment, will not participate in services selected, or when the program receives a written request from the parent/guardian or other committee member. Procedures are outlined for notifications of when a CSC is being held, when the agency receives a written parental request, and provision of a report to the parent/guardian following a CSC. Representation within the CSC is outlined and includes the following: member of the local school district, DJJ, CINS/FINS contract provider, DCF, local law enforcement, community mental health, state attorney, and any other persons deemed appropriate.

The agency does not routinely hold case staffing committee meetings at this time unless there is a written request from a parent/guardian. The Clinical Director reported there have been no specific meeting requests during the past year; therefore, no documentation is available to review for this indicator.

There were no exceptions to this indicator.

## 2.07 Youth Records

Satisfactory

Limited

Failed

### Rating Narrative

The agency has a policy in place for Youth Records. The policy was last reviewed and updated on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

Procedure states the program maintains confidential records for each youth. All files are marked confidential and kept in a secure room or locked file cabinet that is marked confidential. Records that must be transported are done so in a locked opaque container marked confidential. Records are also maintained in an orderly manner so that information is easily accessible. Client confidentiality is protected according to FL

Statutes, and information is only released under allowable circumstances. Limitations of confidentiality are explained to youth and families at intake, and are outlined in the agency's informed consent document.

There were four Residential files reviewed. All files were marked with a confidential stamp and arranged in an orderly manner. Containers used to transport files offsite were observed to be opaque, lockable, and marked with a confidential sticker. The youth and parent/guardian signed/initialed documents relating to confidentiality, and limits thereof. The file room was locked and all cabinets with client files/information were marked as confidential.

There were four Non-Residential files reviewed. All files were marked confidential and arranged in an orderly manner. All files contained signatures of parent/guardian on documents related to confidentiality. Files were transported in an opaque, locked container marked confidential.

There were no exceptions to this indicator.

## 2.08 Sexual Orientation, Gender Identity/Expression

Satisfactory

Limited

Failed

### Rating Narrative

The agency has a policy in place for Sexual Orientation, Gender Identity/Gender Expression. The policy was last reviewed and updated on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

All youth are provided a safe environment and therapeutic case planning regardless of the youth's actual or perceived sexual orientation, gender identity, or gender expression. Youth are addressed according to their preferred name and gender pronouns. Youths preferred name and gender pronouns are used in the logbooks and on all outward-facing documents and census boards.

- All staff, service providers, and volunteers have knowledge of Florida Network policy #5.08 and the terms defined in them.
- Youth in need of specialized support are referred to qualified resources.
- Youth is not roomed in isolation due to sexual orientation, gender identity, or gender expression.
- Youth preference is considered and documented for room assignment.
- Youth will be provided hygiene products, undergarments, and clothes that affirms their gender identity or gender expression.
- The program will have signage placed in common areas, indicating that all youth are welcome regardless of sexual orientation, and gender expression

There have not been any youth admitted to the shelter, since the last on-site review, that meet the criteria for this indicator.

There was signage located throughout the shelter indicating all youth are welcome regardless of sexual orientation, gender identity, and gender expression. Signage was found in the lobby, day room, and staff office.

There were no exceptions to 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 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 six YCS direct care staff members, 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 agency has a policy in place for Shelter Environment. The policy was last reviewed and updated on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

Annual fire inspection was conducted by B&C Fire Safety. Current inspection received a satisfactory rating. Fire drills were documented being conducted per month per shift.

Procedures include guidelines set forth by the Florida Network of Youth and Family Services and the Department of Children and Families (DCF). Shelter grounds should be in good repair, free of insect infestation, grounds and landscape are to be well maintained, the kitchen should be replete with adequate modern, maintained, and operable appliances, and bathrooms for all residents should be equipped with a sink, toilet, and shower. All chemicals are to be listed. Sleeping quarters should be lighted with natural and artificial light and bedding should be clean and neat. The program shall incorporate structured activities including client safety, physical activities, homework and reading, and faith based activities

A facility tour was conducted. Furnishings were observed to be in good repair.

Day rooms were free from debris and hazards. The dumpster and garbage cans all had lids. All doors were secured. A detailed map and egress plan was in each day room and dorm. All agency and staff vehicles doors were locked. Washer and dryer were fully operational.

Kitchen and dining areas were adequate to service youth and operational. The Dietary Specialist approved and signed the posted menu for the youth. The kitchen was replete with food supplies to meet demands.

Bathrooms and showers were observed to be clean. There was no graffiti on the walls, doors, or windows. Lighting was adequate.

Each youth individual bed, had a clean covered mattress, pillow, and blanket. Sleeping quarters were well lit and included natural lighting. The DCF Child Care License was on display in each room utilized by the youth. Program had an adequate supply of linens and towels.

Posting of the youth activities were in each of the day room areas. Activities were scheduled to engage youth in meaningful, structured activities such as; reading, exercise, recreational, faith based opportunities, client safety, and educational classes.

An annual fire inspection was conducted by the Fire Department. Current inspection received a satisfactory rating. Fire drills were documented being conducted per month per shift.

All fire safety equipment inspections were valid and up-to-date. The program had a current satisfactory food service inspection report from the Department of Health. All cold food was properly stored, marked, and labeled. The dry storage pantry was clean and food was properly stored.

Refrigerator was cleaned and maintained at the required temperatures.

Exception:

All Chemicals were not listed on Material Safety Data sheets (MSDS). Three locations were observed to be utilized for chemical storage. The shed had various items not documented on the MSDS to include: eight bottles of liquid dish detergent; six, five gallon gas containers with three missing lids; and a plethora of other chemicals not accounted for. The Kitchen had three dust and lent remover air spray cans not included on MSDS sheets. On more than three occasions items listed on MSDS sheets were not observed in the assigned locations. The upstairs chemical storage was akin to the other two. However, each location was restricted from youth gaining access and all entries required a key maintained by designated staff.

During this site visit, it was observed that all chemicals were not listed on Material Safety Data sheets (MSDS). Three locations were observed to be utilized for chemical storage. The shed had various items not documented on the MSDS to include: eight bottles of liquid dish detergent; six, five gallon gas containers with three missing lids; and a plethora of other chemicals not accounted for. The Kitchen had three dust and lent remover air spray cans not included on MSDS sheets. On more than three occasions items listed on MSDS sheets were not observed in the assigned locations. The upstairs chemical storage was akin to the other two. However, each location was restricted from youth gaining access and all entries required a key maintained by designated staff.

### 3.02 Program Orientation

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy in place for Program Orientation. The policy was last reviewed and updated on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

The orientation is pivotal part of the youth's successful placement. Procedures include program expectations, contraband items, dress code, visitation, mail, and telephone, grievance procedure, disaster preparedness, physical layout of the facility, scheduling, hygiene, access to medical and mental health services, room assignment, and an introduction to staff and other shelter youth.

There were seven youth files reviewed, five open and two closed. Each youth had documentation in their file of the program providing an orientation. The orientation process includes all required elements. Documentation of each component of orientation, as well as signatures of youth and staff involved, was maintained in each youth file reviewed. Each staff was trained in the orientation process.

There were no exceptions to this indicator.

### 3.03 Youth Room Assignment

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy in place for Youth Room Assignment. The policy was last reviewed and updated on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

Procedurally, an initial classification of each youth entering the program is utilized for safety and security concerns. Procedures include a review of information, collateral contacts, initial interactions with other youth, separation violent youth from nonviolent youth, identification of youth

susceptible to victimization, medical, mental or physical disabilities, suicide risk, and sexual aggression and predatory behavior.

There were seven youth files reviewed, five open and two closed. All seven 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.

There were no exceptions to this indicator.

### 3.04 Log Books

Satisfactory
  Limited
  Failed

#### Rating Narrative

The agency has a policy in place for Log Books. The policy was last reviewed and updated on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

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 pink, 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 log book (Electronic Note Active Tablet) was reviewed, with the Quality Service Manager, from July thru September 2018. The log book includes general and specific resident behavioral information, any planned intakes/discharges, and other critical residential care issues. Entries were highlighted appropriately, staff signed in and out every shift, intakes and discharges were documented, incidents were listed with names of clients and details, and errors were struck through. There was documentation that a supervisor was reviewing the logbook each shift. There were weekly reviews by the program director.

There were no exceptions to this indicator.

### 3.05 Behavior Management Strategies

Satisfactory
  Limited
  Failed

#### Rating Narrative

The agency has a policy in place for Behavior Management Strategies. The policy was last reviewed and updated on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

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. 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.

There were no exceptions to this indicator.

### 3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy in place for Staffing and Youth Supervision. The policy was last reviewed and updated on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

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 agency has the staff schedule posted and visible in the staff office. The schedule does identify the days/shifts clearly and a rotation roster which includes the home numbers of staff that may be accessed when additional coverage is needed.

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.

Exception:

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 the week prior to the on-site review, there were eleven out of twenty-one shifts that had no male staff scheduled. Additionally, there were numerous shifts over the past six months with no male staff scheduled. In general, securing male staff at this site is an on-going issue.

Hope House uses "Indeed", an internet based employment site while at the same time their LSF Human Resources Team re-post the job openings on the LSF website. Interviews were conducted approximately three weeks ago with male applicants; however, none of the applicants passed the interview or background screening.

### 3.07 Special Populations

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy in place for Special Populations. The policy was last reviewed and updated on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

Staff secure youth are those who are adjudicated as a Child In Need of Services (CINS) and held in contempt for running away, locked out of their home, and deemed as displaying ungovernable behavior. The agency has procedures in place for these youth being in the shelter for up to 90 days. These include: in-depth orientation upon admission to the program, assessment and service planning, enhanced supervision and security, parental involvement, and collaborative aftercare. Youth designated as 'staff secure' wear a "TAB BAND" that is color-coded to alert staff that this youth is in the shelter under special circumstances.

Youth identified under the Domestic Minor Sex Trafficking (DMST) provision are assigned a one-to-one staff member to engage the youth in positive activities designed to encourage the youth to remain in the shelter. This includes alternative schedules, off-site activities, and adherence to the behavior management program.

Domestic Violence Respite (DVR) services are provided as an intervention for youth and/or families experiencing a high level of conflict. Services are provided to youth with recent delinquency charges related to domestic violence. Youth are initially screened by DJJ staff and referred to LSW-NW when deemed appropriate.

Probation Respite (PR) services are provided to youth currently on probation and at-risk of potentially acquiring an additional delinquency charge and/or violating probation.

Under DVR and PR services medical, mental health, and substance use screenings are conducted within 24 hours of admission. Coordination with the youth's Juvenile Probation Officer (JPO) takes place while the youth is in shelter care.

Youth receiving Intensive Case Management Services (ICMS) are court ordered or referred through the local Case Staffing Committee. Services are provided such that youth and families are connected to an array of services that meet their needs, and prevent them from incurring additional DJJ or DCF involvement. The agency policy states youth receiving these services come from a strengths-based, positive youth development, and trauma-informed approaches. At minimum, the youth/family has 6 face-to-face contacts per month. These contacts may include crisis intervention, individual/family counseling, medical services, ATOD education and treatment, school services, tutoring, etc. Youth are discharged from ICMS upon successful/unsuccessful completion of services or expiration of a court order.

The agency has not had any Staff Secure, Probation Respite, Domestic Minor Sex Trafficking, or FYRAC cases during the current review period. As such, no client files were reviewed for these sections of the indicator.

There were two closed Domestic Violence Respite files reviewed. In both cases the youth was admitted to shelter services based on a pending domestic violence charge, and did not meet criteria for secure detention. One youth was in shelter care for more than 21 days and documentation was present reflecting transfer from the DV respite program to CINS/FINS. Both case plans had goals and objectives focused on anger management, family dynamics, and interventions targeted at reducing family conflict. All services provided to the youth were consistent with general CINS/FINS requirements.

Three Intensive Case Management Services (ICMS) files were reviewed. All three cases were referred due to truancy and/or court involvement relating to delinquency charges. Case plans demonstrate a strength-based, trauma-informed focus in their objectives and goals. Case notes indicate the ICMS counselor making attempts to engage families regularly, advocate on their behalf in educational and court settings, and providing referrals to support systems in the community.

Further to note, it was observed that in two of three ICMS files reviewed a Child Behavior Checklist was not completed at intake. None of the three files reviewed had client self-report measures completed at intake or at any other time after intake.

### 3.08 Video Surveillance System

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy in place for Video Surveillance System. The policy was last reviewed and updated on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

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. There is a list of authorized personnel, who are permitted to access the video surveillance system, hanging in the office. There were several posters letting visitors, staff, and residents know that the surveillance system is use in the facility.

There were no exceptions to this indicator.

## 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 policy on Healthcare Admission Screening. The policy was last reviewed on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

Immediately upon the arrival of a youth to the facility, the nurse, if present, or the YCS performs a preliminary physical health screening to determine if there are any obvious or immediate medical needs. The screening includes a general visual inspection of the youth and a verbal inquiry and observation of medical conditions, recent illnesses, allergies, and physical pain or distress. The nurse or YCS also notes the presence of scars, tattoos, or other skin markings. YCS then completes the CINS/FINS Intake Form and the Shelter Intake Packet. If the physical health screening indicates conditions that necessitate medical care or follow-up, the YCS contacts a counselor in order to make a decision about the admission and/or the need for immediate medical attention. Screenings are completed in a designated area to protect client confidentiality. If the nurse did not conduct the preliminary health screening, he/she will review it within five business days.

There were seven residential files reviewed, four open and three closed. All seven files reviewed contained documentation the CINS/FINS Intake form was completed on the day of intake. There was one youth on medications and this was documented appropriately on the form. None of the youth had any allergies, or existing or chronic medical conditions. However, the agency does have processes in place to involve the youth's parent or guardian to schedule any needed follow-up medical care. There was documentation in five of the seven files the RN reviewed the health screenings section within five days.

There were no exceptions to this indicator.

### 4.02 Suicide Prevention

Satisfactory                       Limited                       Failed

#### Rating Narrative

The agency has a policy in place for Suicide Prevention. The policy was last reviewed on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

LSF-NW has a system in place to screen, assess, and protect youth with risk factors for suicide. Suicide prevention and intervention procedures are practiced in non-residential counseling services and in the shelter. Youth who are admitted into residential services immediately have a comprehensive shelter intake assessment completed by the YCS which includes an initial mental health screening, a suicide risk screening, and an initial substance use screening using the CINS/FINS Intake Form. A screening of suicide risk using the Evaluation of Imminent Danger for Suicide (EIDS) is completed on all clients at intake and at any other time as indicated by behavior after admission to the program. A counselor is contacted by the YCS at any time during the shelter intake when the youth scores in high risk/imminent danger or when the youth is exhibiting behaviors that indicate excessive agitation or extreme withdrawal. If at any time YCS are uncomfortable, or question a client's safety or level of risk, YCS will contact a counselor to discuss placing the client on sight and sound.

Following a clinical assessment of a youth who has been placed on sight and sound supervision, a counselor may determine there is no longer

a need for intensive supervision. Prior to decreasing the level of supervision, the counselor who assessed the youth, staffs the case with a Licensed Professional. This may be done in person or via the telephone. The counselor documents the explanation for the decrease, as well as the name of the Licensed Professional approving and the date the level was dropped on the Suicide Assessment Form. This form is filed in the Testing section of the client's clinical file, on top of the Safety Contract. The counselor also makes appropriate documentation in the NoteActive and in the client's shelter file.

The shelter utilizes two levels of supervision. The first level is Constant Sight and Sound Supervision. This level of supervision is for youth who are identified as being at high risk of suicide but are not expressing current suicidal thoughts or threats. A staff member must have continuous, unobstructed and uninterrupted sight of the youth and be able to hear the youth at all times. The second level of supervision used is One to One Supervision. This is the most intense level of supervision and will be used while waiting for the removal of the youth from the program by law enforcement or parent/legal guardian for the purpose of Baker Act assessment. One staff member, who must be of the same gender as the youth, will remain within arm's length of the youth at all times. The staff must continually observe the youth's demeanor, actions, conversations and behavior.

There were ten residential files reviewed, four open and six closed. All ten files documented the CINS/FINS Intake form was completed on the day of admission. All ten files also documented the EIDS was completed on the day of admission and reviewed by a master's level counselor the same day. Out of the ten files, four youth were placed on suicide precautions due to results from those initial screenings. These four youth were immediately placed on sight and sound supervision. In three of the four cases an Assessment of Suicide Risk was completed within twenty-four hours. In one case the youth was admitted on 9/11/2018 and the Assessment of Suicide Risk was completed on 9/14/2018. One youth was removed from suicide precautions and placed on standard supervision. The remaining three youth were to remain on suicide precautions and be reassessed again in a couple days. One of those three youth was still in the shelter and was still on suicide precautions. The remaining two were reassessed and removed from suicide precautions. In all four cases the Assessment of Suicide Risk was completed by the Master's level counselor and then reviewed with the Licensed Mental Health Counselor (LMHC) via telephone. The LMHC signed the Assessment of Suicide Risk the next time on site. All four cases had thirty minute observations of the youth while on suicide precautions.

There were no exceptions to this indicator.

#### 4.03 Medications

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has a policy in place for Medications. The policy was last reviewed on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

All shelter staff are trained in the procedures for medication storage, access, inventories, disposal and the safe and effective distribution of medication. If new staff are deemed ready, this training is initiated during the first forty hours of employment and includes use of the Pyxis MedStation 4000, review of policies and procedures, observation and the demonstration by the new employee of their understanding of these procedures and practices. All medication in the possession of incoming shelter clients is confiscated and locked in the Pyxis Medstation 4000 and/or refrigerator. This includes both prescription and non-prescription drugs. It is agency practice that all prescription medication for a shelter client is distributed pursuant to the physician's orders. There are detailed procedures in place for Verification of Medication, Access, Inventory, Storage, Medication Distribution, Disposal, and Accountability.

The agency has a Registered Nurse (RN) who is on-site four days a week, Monday thru Thursday. The hours the RN is on-site each vary depending on the needs of the shelter, but it is no more than a total of twenty hours per week. Whenever the RN is on-site she will distribute all medications, if the RN is not on-site a trained staff member on duty will be responsible for distributing medications. The RN also conducts Health Admission Screenings for all youth when they are admitted.

The agency provided a list of eleven staff who are trained to supervise the self-administration of medications. There were six staff on the list who were designated as Super Users. The RN train's all staff on the use of the Pyxis Med-Station and the medication administration process at hire. The RN completes an annual refresher training for all staff each year. This training was completed last month for this calendar year. The training was completed together with the Currie House RN and staff. It included a full day of various trainings on all medication needs and topics associated with the shelter environment. In addition to this annual training, the RN also completes monthly targeted trainings depending on the shelters needs at that time. Remedial trainings are completed for any staff creating a discrepancy or medication error. These staff are required to take a test as part of their remedial training and this documentation is placed in the staff's personnel file.

All medication is stored in the Pyxis Med-Station. Over-the-counter medication is stored in drawer one and prescription medications are stored in drawers two, three, and four. Drawer five is used for over-sized medications. Medications are verified at admission usually by the RN; however, if the RN is not present for the admission the staff will call the pharmacy to verify the medication.

The RN runs a weekly Discrepancy Audit. Any discrepancies for the week are printed out and stapled to the that weeks audit report. The staff member creating the discrepancy receives a remedial training from the RN. In the last six months there were a total of thirty discrepancies. Most discrepancies were due to staff mixing up the starting and ending counts. There were nine discrepancies that were not cleared out by the end of the staff members shift. The RN makes a note in the shift summary and pro log when discrepancies are not cleared and who needs to clear one. Staff are required to clear out their own discrepancies. If the staff does not clear out the discrepancy after the above reminders then the RN will notify the staff's supervisor. There was one open discrepancy at the time of the review. This discrepancy was from the end of August and the

staff member has been on vacation so has been unable to clear out the discrepancy.

In addition to the weekly Discrepancy Audit the RN also runs a All Profile Overrides Audit and Average Number of Cancelled Transactions Audit. A User Summary by Transaction Type Audit is run monthly. All reports are printed out and maintained in a binder.

The shelter has four over-the-counter medications (OTCs), including: Ibuprofen, Jr. Acetaminophen, Pink Bismuth, and Triple Antibiotic Ointment. These four OTCs are inventoried once a week by the RN. These inventories were completed and reviewed for the last six months.

Trained direct care staff complete an inventory every shift of all the controlled substances. This is completed by two staff members and is documented on the youth's Medication Distribution Log (MDL). A perpetual inventory is maintained on the youth's MDL each time a medication is given. Non-controlled medications are inventoried by maintaining a perpetual inventory each time it is given and inventoried one time each week by the RN. The shelter does not maintain any over-the-counter medications that would require a separate inventory. All prescription medications are inventoried each time given and also by maintaining a running, perpetual inventory on the youth's Medication Distribution Log (MDL). All controlled medications are inventoried each shift and documented on the youth's MDL. All medication inventories are also documented in the pro log.

The shelter has a system in place for refrigeration of medication if needed; however, there was no medication that required refrigeration during the time of review. The refrigerator was unlocked and opened by the RN and was observed to be empty and maintaining a temperature of 36 degrees Fahrenheit.

The agency has a process that requires staff to alert the parent or guardian when a youth has five to seven doses of their medication remaining.

Medication must be disposed when left behind by a youth after discharge for more than ninety days. Disposal requires two individuals to verify and confirm that the medication is disposed of properly. Medication is destroyed by the RN 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 two biohazard containers located on site in the YCS office.

The agency maintains sharps. The agency does not accept youth that require syringes with specific dosage requirement that they must maintain and receive during their shelter stay. However, the agency does accept youth 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 sharpener, and nail file. A review of the sharps inventory count binder revealed that sharps are counted one time per week.

The agency uses a medication distribution binder that houses all the individual paper medication logs of each youth on medication. The medication distribution sections for each youth includes a picture of the youth, a form documenting the youth's medications and where they are stored, a prescription medication approval form, an OTC approval form, the youth's MDL, and side effect information on medications the youth is taking. The MDL's document the youth's name, date, physician, side effects, allergies, medication, strength, directions, time due, method of distribution, verification, staff names and signatures, and youth name and signature. There was one youth in shelter on medications at the time of the review. The MDL documented the youth received all medication within the required time frames. The MDL also documented a running, perpetual inventory of the medication and also a weekly inventory of the medication by the RN. This was not a controlled so it did not require shift-to-shift inventories.

It is noteworthy to mention the agency has had three medication errors that have been reported and accepted by the DJJ CCC. A review of these incidents found that a staff person forgot to distribute prescription medication to these youth as required. In all three cases the youth did receive the medication, per the pharmacist orders/recommendations, just late, one received the medication thirty minutes late, another was twenty minutes late, and the last one was approximately two and a half hours late. These staff did receive remedial training and took a quiz after the training. This was confirmed by the RN who completed the training; however, the supporting documentation was not able to be found.

There were no exceptions to this indicator.

#### 4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has a policy in place for the Medical/Mental Health Alert Process. The policy was last reviewed on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

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 seven files were randomly selected to verify the agency's adherence to the requirements of this indicator. All files were appropriately marked for the corresponding documented alerts identified during the screening and intake process.

The agency also uses a pass down log. This one sheet form tracks the condition and status of each youth on a daily basis. All youth were appropriately marked for the corresponding documented alerts. The general alert board located in the Youth Care Specialist office appropriately documented all corresponding alerts. In addition, a review of the logbook verifies the conditions and status of all youth.

There were no exceptions to this indicator.

#### 4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has a policy in place for Episodic/Emergency Care. The policy was last reviewed on September 5, 2018 by the Regional Director, Clinical Director, and Quality Services Manager.

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; documenting 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.

All staff have current training in CPR/First Aid and the use of emergency equipment (knife-for-life, wire cutters, first aid kit). There are first aid kits located in the kitchen, YCS Office upstairs and downstairs, and the vehicles. The contents of all first aid kits are checked monthly by the RN. The shelter has two sets of knife-for-life and wire cutters. One set is located in a box, in the closet of the nurse's office. The second set is located in a box, in a drawer in the upstairs YCS office. A seatbelt cutter, window punch, and air bag deflater are located in each vehicle.

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 the Date; Time; Shift; Duration; Number of staff; Number of clients; Number of Admin Staff and Guests; Comments; and Event. The binder maintains all mock exercises; however, did not document the real events. There have been two episodic care drills in the last six months, they include a suicide attempt and staff having a seizure. Mock CCC reports were completed to go along with each event. There have been two actual off-site episodic care events in the last six months requiring the youth to be transported to the hospital. One event was a youth fainting and the other was a youth falling and hitting their head. Both events were reported to the CCC. Neither event was documented in the Episodic Care Log. Both incidents documented the parent/guardian and Residential Supervisor were notified. An internal incident report was completed for both incidents, as well as, a CCC report. Follow-up instructions/care were also documented. Both incidents reported to the CCC were also found documented in the logbook, with further documentation of parental involvement and follow-up care.

There were no exceptions to this indicator.