



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

Review of LSF SE- Lippman

on 01/28/2019

## CINS/FINS Rating Profile

### Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory:100.00%

Percent of indicators rated Limited:0.00%

Percent of indicators rated Failed:0.00%

### Standard 3: Shelter Care

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

Percent of indicators rated Satisfactory:100.00%

Percent of indicators rated Limited:0.00%

Percent of indicators rated Failed:0.00%

### Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity/Expression	Satisfactory

Percent of indicators rated Satisfactory:100.00%

Percent of indicators rated Limited:0.00%

Percent of indicators rated Failed:0.00%

### Standard 4: Mental Health/Health Services

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

Percent of indicators rated Satisfactory:100.00%

Percent of indicators rated Limited:0.00%

Percent of indicators rated Failed:0.00%

Percent of indicators rated Satisfactory:100.00%

Percent of indicators rated Limited:0.00%

Percent of indicators rated Failed:0.00%

## Rating Definitions

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

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

## Review Team

### Members

Marcia Tavares, Lead Reviewer, Consultant Forefront LLC

Pierre Badoo, Shelter Manager, Crosswinds Youth Services

Carline Jean, Case Manager, Center for Family and Child Enrichment

Ben Kemmer, CEO, Florida Keys Children Shelter

Gabriel Medina, QI Monitor, Florida Department of Juvenile Justice



## Quality Improvement Review

LSF SE- Lippman

Reviewed on January 28, 2019

---

**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 checked="" 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 checked="" type="checkbox"/> Intern                  |
| <input checked="" type="checkbox"/> Clinical Director | <input checked="" type="checkbox"/> Counselor Licensed     | <input checked="" type="checkbox"/> Counselor Non- Licensed |
| <input checked="" type="checkbox"/> Case Manager      | <input type="checkbox"/> Advocate                          | <input checked="" type="checkbox"/> Human Resources         |
| <input checked="" type="checkbox"/> Nurse             |  |   |
| 0 Case Managers                                       | 0 Maintenance Personnel                                    | 0 Clinical Staff  |
| 0 Program Supervisors                                 | 0 Food Service Personnel                                   | 0 Other   |
| 0 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 type="checkbox"/> Key Control Log                             | <input checked="" type="checkbox"/> Youth Handbook             |
| <input checked="" type="checkbox"/> Logbooks                          | <input checked="" type="checkbox"/> Fire Drill Log                   | 3 # Health Records   |
| <input checked="" type="checkbox"/> Continuity of Operation Plan      | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 3 # MH/SA Records  |
| <input type="checkbox"/> Contract Monitoring Reports                  | <input checked="" type="checkbox"/> Table of Organization            | 14 # Personnel Records   |
| <input type="checkbox"/> Contract Scope of Services                   | <input checked="" type="checkbox"/> Precautionary Observation Logs   | 8 # Training Records   |
| <input checked="" type="checkbox"/> Egress Plans                      | <input checked="" type="checkbox"/> Program Schedules                | 5 # Youth Records (Closed)                                     |
| <input checked="" type="checkbox"/> Fire Inspection Report            | <input type="checkbox"/> Telephone Logs                              | 5 # Youth Records (Open)                                       |
| <input checked="" type="checkbox"/> Exposure Control Plan             | <input checked="" type="checkbox"/> Supplemental Contracts           | 0 # Other  |

**Surveys**

3 Youth                      3 Direct Care Staff

**Observations During Review**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Intake                          | <input checked="" type="checkbox"/> Posting of Abuse Hotline         | <input 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 checked="" type="checkbox"/> Searches             | <input type="checkbox"/> Discharge                                   | <input checked="" type="checkbox"/> Group                |
| <input checked="" type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings                     | <input checked="" type="checkbox"/> Meals                |
| <input type="checkbox"/> Social Skill Modeling by Staff  | <input type="checkbox"/> Youth Movement and Counts                   |  |
| <input type="checkbox"/> Medication Administration       | <input checked="" type="checkbox"/> Staff Interactions with Youth    |  |

**Comments**

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

Rating Narrative

## Strengths and Innovative Approaches

### Rating Narrative

Lutheran Services Florida (LSF) is a statewide, non-profit, human services agency with its headquarters located in Tampa, Florida. The agency's mission is to bring healing, help, and hope to all people in need regardless of religious affiliation, age or national origin. LSF has offices and programs in Belle Glade, Crestview, Fort Myers, Fort Walton Beach, Jacksonville, Largo, Lauderdale Lakes, Miami, Milton, New Port Richey, Oakland Park, Orlando, Pensacola, Port Charlotte, Sarasota, St. Petersburg and Tampa. The agency has more than 60 programs located throughout Florida and provides a variety of services including: Refugee and Immigration programs, Guardianship Services, Youth Shelters, Head Start and Early Head Start, the Child Care Food Program, Counseling Services, Disaster Response, Sexual Abuse Treatment Program, Teen Court, Ryan White Program, Case Management for Child Welfare, Foster Care and Adoptions, and Substance Abuse and Mental Health. LSF was accredited by the Council on Accreditation (COA) in 2005 and has consistently maintained re-accreditation effective through February 28, 2022.

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

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

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

FY 2018-19 has been an exciting year for LSF-SE with many changes and improvements. Leading the way in changes is the hiring of Mike Carroll, former Secretary Department Children and Family Services as the Executive Vice President of Programs, a position formerly held by Stacy Martin. Locally, the former Shelter Manager's position vacated by Terence Washington who left on 1/11/2019 to pursue a career opportunity with Mount Bethel Human Services was filled by Guillermo Arauz, the former Counselor II of the Lippman Youth Shelter, who is acting as the manager of the facility in a temporary basis until a permanent replacement can be chosen. Kali Fabal, LCSW has taken on the role as Clinical Director since the last QI review.

The shelter has had several positive developments including the improvement of the shelter facility. Since the last QI review, a new roof was installed. With assistance from a local church, the basketball court and the back wall was repainted. LSF is in the process of procuring a new range for the kitchen. Regarding programming, the continued support of volunteers allows the program to host its Master Chef Cook-off. The Cook Off utilizes volunteers from the community who teach youth how to cook different recipes. Youth are grouped to compete in a cook off and winners are selected and awarded. In addition, the program hosts a poetry showcase and workshop scheduled for Martin Luther King Jr Day. Youth and Staff also participated in Gender Identity and LGBTQIA training hosted by the YES institute from Miami this past fall.

LSF is currently having issues hiring a counseling staff for the non-residential services program. The program has had a vacancy for that position for several months and had offered it to a candidate who ran into background screening issues. The position was actively posted on Indeed and on ADP.

## Standard 1: Management Accountability

### Overview

#### Narrative

LSF Southeast operates both the Lippman Youth Shelter (residential) and Broward Family Center (non-residential) CINS/FINS Program in Broward County. The CINS/FINS program has a management team that is comprised of: an Executive Program Director; a Shelter Services Manager; a Licensed Clinical Director; and a Senior Administrative Assistant. At the time of the review, the program had five vacant positions for 1 non-residential Counselor, 2 fulltime Youth Care staff (YCS), and two part time YCS.

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

The program has an Annual Training Plan for FY 2018-2019. Each year the plan is reviewed, revised, and approved. The plan includes mandatory training for all staff including orientation training for new hires and an in-service component. Employees receive ongoing training from Skill Pro, local providers, and the Florida Network. Each employee has a separate training file that contains a training plan and supporting documentation for training received. Annual training is tracked according to the employee's date of hire.

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

The Department of Children and Families has licensed Lippman Youth Shelter for 20 beds as a Child Caring Agency, with the current license in effect until June 27, 2019.

### 1.01 Background Screening

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a Policy and Procedures, 1.01 "Background Screening of Employees and Volunteer," that was last revised on 10/03/18 and approved on 10/12/18 by the Executive Director, Clinical Director, and Residential Services Manager. The policy and procedures comply with the requirements for background screening of all Department of Juvenile Justice employees, contracted providers, and volunteers as well as anyone else with direct and unsupervised access to youth.

DJJ background screenings are required to be conducted prior to the hiring of employees or volunteers. The agency's Senior Administrative Assistant will check the Care Provider Background Screening Clearinghouse to see if the applicant has a current background screening on file. If the prospective employee's record is not found, the agency will proceed with the submission of a Live Scan. Prospective employees and volunteers are required to complete the appropriate forms required for fingerprinting. Upon receipt of an eligible screening result, the agency will formally make an offer of employment. In addition to the DJJ Background Screening, the provider also conducts driver's license screening for new hires, quarterly driver's license screening for existing staff, annual local municipality and county screenings, and a drug screening upon hire and randomly thereafter. Employees and volunteers are re-screened every 5 years of employment. The agency updates the Affidavit of Compliance with Good Moral Character Standards annually and submits the Affidavit with corresponding attachments to DJJ by January 31st.

A total of eighteen (18) background screening files were reviewed for five (5) new hires, ten (10) volunteers/interns, and three (3) staff that were eligible for a five-year re-screening as of the most recent QI review conducted on January 11, 2018. All five (5) new hires were screened and received an eligible screening result prior to their hire dates. Similarly, the ten (10) volunteers/interns utilized by the provider during the review period were background screened with eligible screening results obtained prior to their volunteer start dates. Additionally, the three (3) staff that were eligible for a five-year re-screening were re-screened prior to their 5-year anniversary dates.

Proof of the faxed submission of the Annual Affidavit of Compliance with Good Moral Character Standards was provided along with evidence showing it was emailed to DJJ on January 17, 2019 prior to the January 31st deadline.

The agency uses Predictive Index (PI), a pre-employment assessment that uses data-driven insights to predict hiring success for Youth Care staff. The program has been using the tool since July 2018. The PI Behavioral Assessment™ provides insights into the individual and their behavioral pattern, categorizes the results, and provides a comprehensive summary along with management strategies to maximize effectiveness, productivity, and job satisfaction. The tool was administered prior to the hiring of one applicable new staff since it was implemented. As of the date of the onsite visit, the provider did not have a written policy in place for its use of the Predictive Index pre-assessment tool with regards to suitability criteria and agency protocol.

No exceptions were noted to this indicator as of the time of the QI Visit.

### 1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has one policy that addresses all elements of indicator 1.02, LSF Southeast policy 1.02- Provision for an Abuse Free Environment. The policy was last reviewed and approved in October 2018 and signed by the Executive Director, Clinical Director and the Shelter Manager.

The agency requires staff to adhere to a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation. LSF Southeast's Employee Orientation packet includes information about the required Code of Conduct, Abuse Reporting. The packet includes an acknowledgement of receipt forms for the employee to sign and the signed copy goes in the employee's file. The policy also requires staff training on Child Abuse reporting to the Florida Abuse Hotline. There are comprehensive procedures regarding the reporting of abuse as well as information about signs of abuse/neglect, licensure requirements, and code of conduct which also includes dress code expectations. The program requires that calls made to the Abuse Hotline be documented in the client's progress notes and or a copy of the report will be placed in the clients file. The policy and procedure also covers the grievance procedure for staff outlining how youth may acquire a written grievance form from staff, which is also a topic of staff orientation. Client Grievance procedure is outlined in the Youth Handbook given to each youth at intake.

Posting of the Abuse Hotline number was observed during the tour on a wall in the youth day room area. The Abuse Hotline number is also included in the youth handbook. The program's policy specifically complies with DJJ policies related to incident reporting, and requires program employees and volunteers to report all known or suspected cases of abuse and/or neglect to the Florida Abuse Hotline. Both staff and volunteers are expected to abide by the agency's rules of conduct that foster an abuse-free environment and prohibit intimidation, physical abuse or force. All new staff members receive training regarding the requirement of reporting incidents of alleged child abuse as a part of their initial orientation training.

The program also has a grievance policy in place that requires families and youth to be informed of their right to grieve; youth acknowledge their understanding of the process by their signature at intake. The program maintains blank grievance forms easily available for all clients. A grievance box is mounted next to the laundry room/common area for depositing of completed grievances. Per the agency's procedures, completed grievance forms should be given directly to a manager or placed directly in the grievance box. The program has no reported grievances in the past six months.

No exceptions were noted for this indicator.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has one policy that addresses all elements of indicator 1.03, LSF Southeast policy 1.03-Incident Reporting. The policy was last reviewed and approved in October 2018 and signed by the Executive Director, Clinical Director and the Shelter Manager.

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

During the reporting period, (9) incidents were reported and met CCC criteria and was accepted by the CCC. Seven CCC incidents were reported within the two-hour limit with follow-up. Two CCC incident reports were called in late. Incidents reported on 8/29/2018 and 11/14/2018 are beyond the two hour time limit. The CCC confirms that 7 incidents were reported to the CCC within 2 hours of the incident and/or gaining knowledge and one incident was classified as failure to report. All notifications and corrective action were handled as stated in the policy. Follow-up documentation was noted in all incidents.

Incidents reported on 8/29/2018 and 11/14/2018 are beyond the two hour reporting time requirement.

### 1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy 1.04, Training Requirements, that addresses all elements of indicator 1.04. The policy was last reviewed and approved in October 2018 and signed by the Executive Director, Clinical Director and the Shelter Manager.

LSF Southeast policy 1.04 states 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 and 24 hours of training each year after the first year. Direct care staff in residential programs licensed by DCF is required to have 40 hours of training per year after the first year. Training for staff includes training as required by DJJ, Florida Network of Youth and Family Services, DCF, COA and any other funders.

Three first year training files were reviewed. All three first year training files contained all required training due within the first 120 days of employment and the three staff had exceeded the 80 hours required annually. Files reviewed documented evidence of Skill Pro, Florida Network and instructor lead training.

Three training files reviewed met the criteria for documentation of non-licensed mental health clinical staff training in assessment of suicidal risk. All three staff received the required Non-Licensed Mental Health Assessment of Suicide Training. The three non-licensed clinical staff had completed the required Assessment of Suicide Risk training with documentation including written confirmation b a licensed professional of the training documenting dates, signature, and license number of the licensed professional.

Three ongoing training files were reviewed. All three ongoing training files contained the required annual training topics and all three had exceeded the 40 hours of training required annually.

The program maintains well organized individual training files for each staff that includes an annual training log which documents required training, dates of completion, and number of hours completed. The file also includes documentation such as certificates, sign-in sheets, and agenda for each training. Training files are maintained by the Lead Program Assistant.

No exceptions were noted for this indicator.

**1.05 Analyzing and Reporting Information**

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedures 1.05 for Analyzing and Reporting Information which was last reviewed 10/2/18 and approved on 10/12/18 by the Executive Director, Clinical Director, and Residential Services Manager. In addition, there is a comprehensive agency-wide Performance Quality Improvement (PQI) that includes detailed procedures to collect, review, and reports various sources of information to identify patterns and trends.

Per the agency's procedures, the program collects and reviews several sources of information to identify patterns and trends including:

1. Quarterly case record review reports. These reviews may be completed by peers.
2. Quarterly review of incidents, accidents and grievances.
3. Annual review of customer satisfaction data.
4. Annual review of outcome data.
5. Monthly review of NetMIS data reports.

The specific procedures for analyzing and reporting data are documented in the agency's PQI Plan for FY 2018-2019. The program assigns individual staff as Chairpersons to represent committees responsible for the collection of various data required by the indicator. A formal list was not maintained but the residential and non-residential program managers provided the names of the Chairs to the Reviewer onsite. The Chairs are responsible for collecting data from the programs on a monthly basis for Case Record reviews; Incidents, Accidents, and Grievances; Customer Satisfaction Surveys; and Outcome Data. Data received is entered into the agency's online database. Netmis data is emailed to the management staff on a weekly basis for review and follow up. The data is compiled by the agency's CQI Director into reports that includes a summary of the incidents/accidents, grievances, and fire drills that occurred during the quarter, summary of case record reviews, reporting of performance measurements for the quarter, number and types of training provided to staff, and satisfaction surveys completed. The program reviews the reports at monthly management and staff meetings. The Executive Director also posts outcomes data and corrective action plans on a board, which is accessible to staff, at the Administrative office. Findings are regularly reviewed by management and communicated to staff



and stakeholders.

Per the Clinical Director, case record reviews are conducted at least twice per month in the residential program and monthly for non-residential files. A review of case record reviews during the review period demonstrated the residential program completed monthly case record reviews on a weekly basis in July, August, and October; 3 times in September and December; and twice in November. As required, the non-residential program conducted monthly case record reviews between July-December 2018. The provider maintains a binder with case record reviews for each program. A copy of each review is maintained in the client file reviewed.

Data regarding the number of incidents/accidents and grievances is entered into the agency's PQI Monthly Spreadsheet Companion Report. The spreadsheet captures a variety of data for all of the programs statewide and monitors the numbers of incidents, accidents, and grievances. Incidents/accidents are tracked on the companion report monthly by level of severity. A copy of the data entered for the review period was reviewed from July- December 2018. Should negative trends be observed, a corrective action will be implemented as a priority issue to be addressed on the companion report. Per the provider's procedures, incidents/accidents and grievances are reviewed at staff meetings. A review of the agendas for monthly staff meetings held since July 2018 showed evidence of discussion of incidents/accidents during the review period. The trends and types of incidents are discussed during the staff meetings.

The CINS/FINS residential program reported no grievances during the review period. Grievances, when they occur, are tracked and documented on the PQI Monthly Spreadsheet Companion Report that aggregates the data statewide. A review of the agendas for monthly staff meetings held since July 2018 showed grievances as listed as an agenda item during the review period.

The programs collect customer satisfaction survey data monthly and enter the number completed each month by program into the PQI Monthly Spreadsheet Companion Report. For the review period, the residential program reported a customer satisfaction level of at least 90% for consumers surveyed and the non-residential program reported a 99% satisfaction rate. A review of the agendas for monthly staff meetings held since July 2018 showed evidence of discussion of client satisfaction surveys during the six months reviewed.

The provider has established program outcomes and collects data monthly on the PQI Monthly Spreadsheet Companion Report by program. Data collected includes benchmarks and performance measures such as: client satisfaction; client functioning; staff turnover; incidents/accidents; grievances; care days; training; exits; and follow ups. PQI, outcomes, and NetMIS data is reviewed and discussed at monthly staff meetings and quarterly management meetings and are documented in the minutes.

Florida Network data is entered, tracked and documented in the PQI Monthly Spreadsheet Companion Report. The data was reviewed onsite for the period July – December 2018. In addition, the Program Director shares this data with staff via emails. There is also evidence of this information being shared with program staff at staff meetings and the outcomes are posted for staff to view at the Administration office. A review of the agendas for monthly staff meetings held since July 2018 showed evidence of discussion of program improvement data during the six months reviewed.

There are no exceptions noted for this indicator.

### 1.06 Client Transportation

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has one policy that addresses all elements of indicator 1.06, LSF Southeast policy 1.06-Client Transportation. The policy was last reviewed and approved in October 2018 and signed by the Executive Director, Clinical Director and the Shelter Manager.

LSF Southeast procedure addresses the following:

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

The agency has procedures outlining several aspects of client transportation. It states staff must ensure they are never in a one-on-one situation with any youth while transporting. When another Youth Care Staff is unavailable to assist with transportation, the youth care staff may utilize interns, volunteers, or may utilize other youth during transport. Only in extreme cases are staff permitted to transport youth one-one; however, they must receive permission from the Shelter Manager to do so. The Staff member driving the youth must maintain an open phone line with shelter staff via cell phone. This approval must be documented in the van log by the van driver. A list of authorized drivers will be kept by the program's Senior Administrative Assistant. All staff must make themselves aware of behavior management alert code information and plans for the clients for who they are providing transport. Each vehicle owned or leased by the program will have a van logbook. Each book will record the name and signature of the driver, where they are traveling to, and the odometer readings traveled. The log book must be completed for each trip the van makes even if clients are not present. Vehicles will be inspected on a weekly basis by the designated YCS III and all issues/problems

will be reported to management as soon as they are observed. All vehicles used to transport youth shall be equipped with first aid kits, a fire extinguisher, seat belts, a seat belt cutter, and a window punch. The program will maintain adequate supplies and place orders as needed and on a regular basis.

Vehicles are inspected on a weekly basis by the designated staff and all issues/problems are documented using the vehicle transportation inspection form. All vehicles used to transport youth are equipped with first aid kits, a fire extinguisher, seat belts, a seat belt cutter, and a window punch. According to the Indicator 1.06, if a driver is transporting a single youth in a vehicle, there must be evidence of a supervisor being aware prior to the transportation and consent is to be documented accordingly on the vehicle log. A review of the logbooks reflected there was supervisor approval of one-on-one transportation with a single staff member and a single youth on 11/7/2018, 11/13/2018, 11/14/2018, 11/15/2018, 11/16/2018.

No exceptions were noted for this indicator.

### 1.07 Outreach Services

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has one policy that addresses all elements of indicator 1.07 LSF Southeast policy 1.07 Outreach Services. The policy was last reviewed and approved in October 2018 and signed by the Executive Director, Clinical Director and the Shelter Manager.

The program provides presentations in the community and distributes written information about their services. These written documents include annual reports, brochures, and posters. The Executive Director, Managers, and the Outreach Specialist recruit collaborative partners based on identified needs.

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

The agency maintains 39 interagency agreements that meet all contractual requirements. The agreements are held with a variety of community partners including mental health, substance abuse, truancy, safe place sites, employment services, educational, medical services, and support services. The agency also keeps a binder with outreach activities completed by the administrative or counseling staff. A separate binder also contains meeting minutes for attendance to DJJ Circuit Meetings. There was evidence of participation and attendance by the management staff or other designated staff to the Circuit 17 DJJ Advisory Board meetings.

No exceptions were noted for this indicator.

## Standard 2: Intervention and Case Management

### Overview

#### Rating Narrative

Lutheran Services Florida Southeast is contracted by the Florida Network to provide both residential and nonresidential services for youth and their families in Broward County. The agency has trained personnel in place to complete centralized intake and screening twenty-four hours per day, seven days a week year round to status offenders that include runaways, truants, ungovernable and lockout youth. Staff have been trained to evaluate the needs of youth and their families and make recommendations based on what services are most appropriate at the time of contact.

Lutheran Service's residential and non-residential services within the program include intensive crisis counseling; parent training; individual, family and group counseling services; runaway center services, community mental health services; case managing services and substance abuse prevention education. Other services offered but mostly catered to Residential clients are Special Education, Tutorial and Remedial Services and Recreational Services. Referrals and aftercare services commence when the youth are admitted for services. Aftercare planning includes referring youth to community resources, ongoing counseling, peer support, advocacy, and educational assistance.

The agency also has in place a case staffing committee when all other services have been futile or exhausted. A new case plan is created with the youth and family through recommendations through the case staffing committee. The case staffing committee may include representatives from the school district, DJJ or CINS/FINS provider, State Attorney's Office, Mental Health and Substance Abuse organizations, law enforcement, and DCF.

### 2.01 Screening and Intake

Satisfactory
  Limited
 Failed

#### Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the QI indicator 2.01. All the policies and procedures were last approved by both Executive Director and Clinical Director on October 12, 2018 and by the Residential Manager on October 17, 2018. The policy states that centralized intake services include screening for eligibility, crisis counseling, educational information, and referral.

The initial screening for eligibility occurs within seven (7) calendar days of referral by trained staff member using the NetMIS screening form. Youth and parent/guardians receive the following in writing during intake:

1. Available service options
2. Rights and responsibilities of the youth and parent(s)/guardian(s)
3. Possible actions occurring through involvement with CINS/FINS services (i.e. case staffing committee, CINS petition, CINS adjudication); and
4. Grievance procedures

A total of six files were reviewed for three (3) residential (2 open, 1 closed) and three (3) non-residential files (2 open, 1 closed). All six case files contained screenings that had been conducted within seven (7) calendar days of referral. All six case files contained verification that the youth and parents/guardians were provided with information related to available service options, rights and responsibilities of youth and parents/guardians, possible actions occurring through involvement with CINS/FINS services, and grievance procedures. All files contained signed documents by the clients, parents, and assigned mental health counselors. The files were also reviewed and signed by a supervisor.

No exceptions were noted for this indicator.

### 2.02 Needs Assessment

Satisfactory
  Limited
 Failed

#### Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the QI indicator. All the policies and procedures were

last approved by both Executive Director and Clinical Director on October 12, 2018 and by the Residential Manager on October 17, 2018.

The provider's procedure for this indicator is clearly outlined and indicated that the needs assessment shall be initiated within 72 hours of admission, if the youth is in shelter care or within 2 to 3 face-to-face contacts following the initial intake if the youth is receiving non-residential services or updated if the most recent assessment is more than six months old. This provider ensures that Needs Assessments are completed on a timely manner in accordance to the Florida Network's guidelines. The assessment is completed by a Bachelor's or Master's level staff member and is signed by a supervisor who is licensed in Mental Health Care.

A total of six files were reviewed for three (3) residential (2 open, 1 closed) and three (3) non-residential files (2 open, 1 closed). All three residential case files reviewed had a Needs Assessment initiated within 72 hours of admission. All three (3) non-residential files contained Needs Assessments that were initiated and completed within 2-3 face-to-face visits. All files reviewed contained a summary of the needs assessment and were signed by a BA or MS level staff member and signed by a licensed supervisor.

No exceptions were noted for this indicator.

### 2.03 Case/Service Plan

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the QI indicator 2.03. All the policies and procedures were last approved by both Executive Director and Clinical Director on October 12, 2018 and by the Residential Manager on October 17, 2018.

The agency's policy describes in detail the program's practice and the expectation that the service plan includes goals, measurable objectives, locations, target date and also the staff's responsibility in assisting with the goals outlined. It also states that the service plan is reviewed every 30 days and documented in case notes in the file. Additionally, the procedures describe the agency's practice for assigning a counselor who is responsible for executing the service plan at completion of the assessment process.

A total of six files were reviewed for three (3) residential (2 open, 1 closed) and three (3) non-residential files (2 open, 1 closed). Each file contained a tailored case/service plan based on the needs of each youth/family reviewed. All the case plans were implemented with the participation of the family. The goals listed on the service plan were measurable objectives with specified service locations and persons responsible for the achievement of each goal. One of the residential files was closed before the completion of the target date and one was recently opened and therefore target date had not yet been reached and/or goals were not yet achieved. In the three non-residential files reviewed, one of the service plans was completed 4 days after the due date.

One of the residential files reviewed indicated the child scored low to moderate on marijuana substance usage. The counselor stated that a referral was to be made. There is no evidence of the referral listed in the file or any goals in the service plan to address the child's needs. Per the Clinical Director, the child was already receiving substance abuse services with Chrysalis and a referral was not warranted.

In one of the non-residential files the service plan reviewed was conducted 4 days after the due date. The service plan was initiated on October 1, 2018 and the 60-day review was completed on December 04, 2018; however, the 60-day review should have been conducted on or before November 30, 2018.

No exceptions were noted for this indicator.

### 2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the QI indicator of 2.04. The policies and procedures were last approved by both Executive Director and Clinical Director on October 12, 2018 and by the residential manager on October 17, 2018.

The agency establishes the needs to the clients based on the developed needs assessment. This policy is in place to coordinate, provide family support, and facilitate additional services when needed. The procedures entail that each youth is assigned a counselor/case manager who will monitor the client's case and provide an array of services that utilizes appropriate resources for children and their families.

A total of six files were reviewed for three (3) residential (2 open, 1 closed) and three (3) non-residential files (2 open, 1 closed). Each file demonstrated each client was assigned to a counselor. The assigned counselor ensures all youth/families served were provided with case management and service delivery such as establishing referral needs, coordination referral to services, monitoring the youth's and family's progress and providing support to the family when needed with the exception of one case. One (1) of the three residential cases indicated that the child had a substance abuse history. An AADIS (Adolescents Alcohol and Drug Involvement Scale) was completed on the youth which indicated the need for a referral. After a complete review of the file, there was no evidence of a referral made and there was no documentation to support that the substance abuse issues were addressed and/or monitored. The Clinical Supervisor indicated the youth was already receiving services through Chrysalis and did not need a new referral.

No exceptions were noted for this indicator.

## 2.05 Counseling Services

Satisfactory

Limited

Failed

### Rating Narrative

The agency has a written policy that addresses the key elements of the QI indicator of 2.05. However, the procedures appear to be only focused on non-residential services and do not address counseling services offered in the residential setting. The policies and procedures were last approved by both Executive Director and Clinical Director on October 12, 2018 and by the residential manager on October 17, 2018.

Per policy 2.05, counseling and group services are provided to all youth based on the goals outlined in the client's service plan. Groups will be provided a minimum of five times weekly and be structured as follows:

- A clear leader or facilitator
- Relevant topic-educational/informational or developmental
- Opportunity for youth to participate
- 30 minutes or longer

The agency's non-residential program provides therapeutic community-based services designed to provide the intervention necessary to alleviate crisis in the family unit, keep families intact, minimize out-of-home placement, provide aftercare services for youth returning home from shelter services, and prevent the involvement of youth and families in the dependency systems.

A total of six files were reviewed for three (3) residential (2 open, 1 closed) and three (3) non-residential files (2 open, 1 closed). All files indicate that counseling services were made available to all clients, either through referral services or in-house treatment. In the residential setting, group counseling is being offered 7 days a week and sometimes twice daily.

Group counseling is offered from Sunday to Saturday at different times throughout the day to ensure that all clients served are able to participate in the services offered. The three youth files reviewed showed the youth participated in groups at least five days/week when present in the shelter. Most of the sessions are being conducted by the counseling staff; however, the youth care staff on schedule are also able to conduct informal group sessions called Highs, Lows and Goes (house meeting groups). Due to the informality of the latter group sessions, documentation demonstrating compliance with the criteria of group sessions was not present or maintained in the group session's folder.

The agency's procedures appear to be only focused on non-residential services and do not address counseling services offered in the residential setting.

No exceptions were noted for this indicator.

## 2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

### Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the QI indicator 2.06. The policies and procedures were last approved by both Executive Director and Clinical Director on October 12, 2018 and by the Residential Manager on October 17, 2018.

The agency has established a case staffing committee in the event the youth/family is not in agreement with services or treatment; the youth/family will not participate in the services selected; or the program receives a written request from a parent/guardian or any other member of the committee. The institution of the case staffing committee is to ensure appropriate services and proper recommendations are made for legal process of filing CINS petition. The program's case staffing meetings occur monthly and additional meetings may be held if, requested, including emergency case staffing. The outcomes and documentation of results of case staffing committee meetings is maintained in each client's file and reviewed by the Manager.

One (1) applicable non-residential file was reviewed for this indicator. The case file listed the staff as the individual initiating the case staffing and the staff followed the proper protocol for scheduling a case staffing. The counselor initiated the staffing and hand delivered the letter notifying the parent of the case staffing within 5 working days of meeting. Similarly, notifications to the staffing committee were sent in accordance with the required time frame and the agency's policy. Parties present at the case staffing included: a local school district representative, a DJJ representative and/or CINS/FINS provider, State Attorney's office, mental health representative, and a substance abuse representative. As a result of the case staffing, a new case/service plan was implemented and signed by both the client and the parent. A review summary was completed by the assigned counselor prior to the court hearing which is scheduled for January 30, 2019.

No exceptions were noted for this indicator.

## 2.07 Youth Records

Satisfactory

Limited

Failed

### Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the QI indicator 2.07. The policies and procedures were last approved by both Executive Director and Clinical Director on October 12, 2018 and by the residential manager on October 17, 2018.

The provider's procedure includes the following requirements: all case files are marked confidential; each client case record shall include chronological sheet and youth demographic data, program information, correspondence, service/treatment plans, needs information, case management information and other materials relevant to the case; all files are kept behind a locked door in a file cabinet that is marked confidential; upon discharge the files are signed by a program manager and maintained in a locked file room in the file cabinets marked confidential; files are maintained by the lead program assistant for a period of two years then transferred to a central storage unit and maintained for a period of 7 years; and all files are maintained in neat and orderly manner.

All 7 files reviewed were maintained in a neat and orderly manner so that staff can promptly and easily access information and were marked confidential and kept in a secure manner. Residential youth records are maintained in a locked file cabinet in the staff office in the shelter and non-residential files are maintained in a locked cabinet in the administrative building. The files are transported in a large, black, digitally locked rolling case marked confidential. Files are maintained in a neat and orderly manner.

The agency's policy stated "Both residential and non-residential files are kept behind a locked door in file cabinets that are marked "Confidential". In the administrative building, all the files were kept in a secure room in file cabinets. However, none of the file cabinets in the room were marked confidential. Upon notification, the agency rectified this issue and confidential stamps were placed on all the file cabinets

found in the administrative building.

There were no exceptions for this indicator.

## 2.08 Sexual Orientation, Gender Identity/Expression

Satisfactory

Limited

Failed

### Rating Narrative

The program has a written policy 2.08 to ensure a safe and therapeutic environment for youth regardless of sexual orientation, gender identity, and gender expression. The policy was implemented on 08/30/2018 and was signed and dated by the Executive Director, Clinical Director, and Residential Services Manager.

Per the agency's procedures, In order to ensure all youth feel respected, valued and safe regardless of their sexual orientation, gender identity, or gender expression Lutheran Services Florida-SE will ensure that:

- 1) Upon entering the facility each youth will be asked a preferred name as well as their pronouns used when referring to them.
- 2) This name and pronouns will be the name used on the census board, on the outside of the youth's file, and in the logbook.
- 3) All staff, volunteers and service providers will review this policy and indicate their understanding by signing off on a copy of this policy during their initial training period. All current staff will be trained annually during a staff meeting.
- 4) Youth needing additional supports will be identified by the youth's counselor and referred to the most appropriate service provider.
- 5) No youth in our care will be housed separately solely based upon their gender identity or gender expression. During intake the youth's gender identity and expression and choice will be considered and documented for making room choices. Should we be unable to accommodate the youth due to safety or other concerns that must be documented on the room assignment sheet in the file.
- 6) All youth are given hygiene products, undergarments, and clothing that affirm their gender identity or expression.
- 7) Lutheran Services Florida-SE will be a warm welcoming atmosphere and show signs in public places of support for youth regardless of sexual orientation, gender identity and gender expression.

During a tour of the facility, just one "LGBTQ" rainbow flag was posted on a board in the counseling hallway of the shelter. Similar signage indicating that all youth are welcome and should feel safe regardless of sexual orientation, gender identity, and gender expression was not observed to be visibly located in other common areas of the facility. Per the Clinical Director, the counseling office also has a poster that lists available hotlines and online resources for LGBTQ youth.

The program also has two types of brochures to provide education and information about LGBTQ: one from the National Runaway Safeline available in English and Spanish entitled "Being Out, Being Safe" and a second brochure provided by the FN called "I Provide Safety Support and Respect". Neither of these brochures was on display at the shelter but the program has copies available to distribute to youth as needed. Youth identified as needing support services are referred to SunServe, a local nonprofit organization that offers multiple resources for LGBTQI youth as well as life coaching groups twice per week. The program did not serve any youth who met the criteria for the indicator; therefore the reviewer was not able to assess practice with regards to youth preferences and case planning. The 3 new staff received LGBTQ training and acknowledgment of the SOGIE policy. A sign in sheet was provided demonstrating in-service staff had reviewed the SOGIE policy guidelines outlined in FN policy 5.08.

Interns are required to receive training specific to providing cross-cultural counseling as part of their core training requirements that must be completed prior to engaging in an internship. A copy of the core requirements for the Nova and FIU interns was reviewed onsite that listed the training requirement. Non-intern volunteers working directly with youth will receive similar training required for employees.

No exceptions are documented for this indicator.



## Standard 3: Shelter Care

### Overview

#### Rating Narrative

LSF Southeast operates its residential program, Lippman Youth Shelter, licensed by DCF through 6/27/2019 for 20 beds. The shelter provides residential services to youth in the Department of Juvenile Justice (DJJ) CINS/FINS program. Lippman shelter is also designated as a provider of staff secure, domestic violence respite services, domestic minor sex trafficking services, and Family/Youth Respite Aftercare Services (FYRAC). The ED indicated that due to zoning issues, the program cannot provide probation respite services as a result of pending DJJ charges for those youth. In addition, the program is not contracted to provide Intensive Case Management Services. During the review period, the program did not serve any domestic minor sex trafficking or FYRAC youth.

The Lippman Youth Shelter has one dormitory wing separated by a hallway. Half of the bedrooms are used for male clients and the other half for females. Youth are separated based on census needs. An individual room close to the staff desk is utilized for clients with special alerts. The facility also has a large common area used for watching television, groups and other activities. The dormitory, kitchen, restrooms and common areas were clean during the tour of the facility. The program has adequate space for all activities and is equipped with a new 25 camera system that allows complete surveillance in and around the outside of the building.

Youth are assigned closets that lock to store their personal belongings. Beds are lettered and youth are assigned to individual beds furnished with bed coverings and pillows. Youth have access to a large yard for outdoor activities.

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

### 3.01 Shelter Environment

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy and procedures that address all of the key elements of this indicator regarding maintaining a safe, clean and neat shelter environment. The policies were last reviewed on 10/12/18 by Executive Director, Clinical Director and Shelter Manager.

Health and fire safety inspections are to be conducted annually. Shelter furnishings are to be kept in good repair for aesthetic reasons and to ensure safety in the use of those furnishings. The shelter building and grounds are to be treated at least once each quarter by a professional pest control company. The shelter exterior is to be maintained as required seasonally by a professional landscaping company. Bathrooms and shower areas are to be inspected by shelter staff at least once on each shift. All rooms are to be inspected for contraband and graffiti a minimum of once each day.

At admissions each youth is to be assigned their own bed, pillow and bed linen. Each room is to have sufficient lighting for reading or to perform other tasks in shelter. Youth may request that any personal belongings be kept in a locked place. Those belongings are to be placed in a plastic bag with the youth's name attached to it and locked in a file cabinet located in the Youth Care's Office.

During the tour of the facility, an inspection of the shelter environment was conducted. The facility appeared to be overall clean, neat and well maintained. All furnishings appear to be in good repair. Washer/dryer is operational and general lint collectors were clean upon review. The program was found to be overall free of insect infestation although a live spider was observed in shower stall of youth bathroom and one live silver dollar in dorm room 4. Routine general pest control services were completed monthly 1/18/19, 12/7/18, 11/2/18, 10/5/18, 9/7/18, and 7/13/18 per invoices reviewed. The overall facility is free of graffiti although dorm room 4 had minor graffiti on wall near bed and on cork board; staff was able to remove immediately once mentioned.

On the outside of the facility, there is a large area for recreation with a half basketball court, boxing bas, and area for large muscle activities. The facility grounds are free of hazards and landscape was well maintained. Dumpster and garbage can(s) are covered; however, reviewer found slight debris in yard (near backyard and front area near facility vehicles) but staff was able to remove immediately once informed.

There is adequate lighting throughout facility. All 5 youth dorm bathrooms and public restrooms were maintained and were functional. However, there was a slight discoloration, possibly mold, in 2 out of the 5 shower stalls. All youth dorms are in compliance with agency policy. Beds are labeled with A, B, C and linen is cleaned weekly but youth are able to wash linen anytime upon request.

Youth have a safe lockable place to keep personal belongings in locked closet in hallway for hygiene supplies and locked black cabinet in the medical room for personal belonging. The hygiene closet is well maintained and organized with clear binders assigned to list each youth's hygiene supplies.



A shift lead staff is assigned keys at change of shift which is notated in the electronic logbook. All doors are secured, in and out access is limited to staff members, and key control is in compliance.

Facility is equipped with knife-for-life (kept in the common area by the staff desk); first aid kits (stored in the dining room, living room area, and one in each of the 3 vehicles); wire cutters; and bio-hazard waste disposal bin(s).

During the review, the agency vehicles were observed and were secured, clean and had working seat belts. The vans had first aid kits, fire extinguishers, current registration & insurance and multi-task tool (able to use as a seat belt cutter, glass breaker, flash light). Monthly vehicle checks are completed by the designated staff.

The facility has detailed egress plans throughout the facility, client rules, grievance forms, abuse hotline info, DJJ incident reporting number and other vital information posted in common areas (all the youth dorms, counselor office, and living room/staff desk).

Agency has a current DCF Child Care License (6/28/2018 current for 20 youth and renewal is due by 6/27/2019) which is displayed in the facility. All health and fire safety inspections are current as follows: 10/01/2018 last health inspection conducted; 7/31/18 last food service inspection; and 5/08/2018 last annual fire safety inspection.

Agency has a menu posted and signed by licensed dietician annually. There is a separate fridge for youth to store leftovers and youth are able to access at any time. All fridges/freezers are equipped with thermometers and maintained at required temperatures. All food is properly stored, marked and labeled and pantry area is clean and food is properly stored.

The agency keeps all chemicals in two large industrial PVC container bins locked outside near backyard. All chemicals are approved for use, inventoried, stored and MSDS are maintained on each item. There are currently 21 different MSDS chemicals listed for an overabundance of chemicals in/not in use.

The agency has a policy and procedures that include a comprehensive safety and emergency disaster preparedness plan updated 8/22/17. The emergency response plan includes all forms of emergencies, special considerations for residential program, hurricane preparedness/emergency kit inventory/ bomb threat and checklist. Review of documentation for the last six months of fire drills and mock drills revealed the drill logs were all well documented and the agency met requirement by successfully completing one at least on a monthly basis.

Youth are engaged in meaningful, structured activities seven days a week during a wake hours. Some of the activities include but not limited: educational, recreational, life, counseling and social skill training. Idle time is minimal. Daily schedule reflect at least one hour of physical activity is provided daily and notated in the logbook on each occurrence listed as fitness or LMA. Youth are provided the opportunity weekly to participate in faith-based activities. Non-punitive structured activities such as reading, journaling, tutoring, education, recreational board game and counseling are offered to youth as an alternative to youth who do not choose to participate in faith-based activities. Agency has also had activities for the youth such as "interview for success", "Master Chef Cook Off", a quarterly make over day, and staff vs. youth events. Daily programming includes opportunities for youth to complete homework and access books in the facility library that have been approved by the agency. Youth are allowed to read in their rooms. The majority of the library books are kept in the living room area. Daily programming schedule is publically posted in the two areas (living room and provided to the youth) and accessible to both staff and youth.

During inspection of the first aid kits, ointments and liquids were out of compliance in van 143 (antiseptic spray 7/2011 and eyewash 6/2011). Van 914 was lacking items but none were expired. Van 205 had expired Neosporin (1/2018) and Motrin IB (11/2018). Additionally, there was no perpetual weekly first aid kit checklist found upon request.

Chemical inventories are not occurring weekly. No inventories were observed for the complete month of December 2018 and January 2019. Weekly checks were done up until 12/4/18 then stopped and no inventories were completed since 12/4/18. The requirement is a minimum weekly. In addition, two chemicals in use were not listed on the chemical inventory.

### 3.02 Program Orientation

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy and procedures that address all of the key elements of this indicator. The policies were reviewed on 11/9/14 and revised 9/21/15. The policy and procedures are signed on an annual basis and last reviewed on 10/12/2018 by the Executive Director, Clinical Director and Shelter Manager.

The agency has established procedures related to admissions, interviewing and room assignment to warrant the safety of all youth placed in the residential facility by completing initial assessment which determines the most appropriate room assignment based on the youth's needs. Youth admitted to the shelter go through a comprehensive client orientation process consisting of seven specific areas documented on the Client Orientation Check List at the time of intake along with being provided a detailed resident & parent orientation handbook.

A review of three residential program orientation files (two open and one closed) indicates that all three clients received a comprehensive orientation during the intake process which is documented on the Client Orientation Check List initialed by staff and youth. All three charts reviewed had acknowledgement from the youth of receiving a comprehensive orientation handbook, disciplinary action explained, grievance procedure explained, emergency/disaster procedures, contraband rules, physical facility layout map, room assignment and suicide prevention

alert notification which is explained by LSF staff. All three residential files had parent/guardian and youth signature obtained on all intake documents. During orientation client signs client rights and responsibilities, daily activities are reviewed, and the hotline number is provided.

No exceptions were noted for this indicator.

### 3.03 Youth Room Assignment

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a detailed policy and procedures that include all components that meet the general requirements of youth room assignment. The policies were reviewed on 11/7/14 and revised 9/21/15. The policy and procedures are signed on an annual basis and last reviewed on 10/12/2018 by the Executive Director, Clinical Director and Shelter Manager.

A process is in place that includes an initial classification of the youth's room assignment on the CINS/FINS Intake Form during admission for safety and security concerns. The agency also has a practice of utilizing a color coded alert system to notify staff of youth with special needs and/or risks. The agency has a nine bedroom shelter with a total of 20 beds that are available for youth.

Three residential files were reviewed (one closed and two open files) and all files had clients receiving general classification and room assignment while being admitted in the shelter. In addition, each youth file was assessed and initial classification information included a review of the youth's age, gender, height, weight, and physical size of client. For classification, all client history is gathered for criminal offenses/delinquency, assault or aggressive behavior, gang involvement, sexual assault, chronic runner, mental health, substance abuse and initial collateral contacts. Each youth had alerts which were noted on the alert board and on the front of the file folder.

No exceptions were noted for this indicator.

### 3.04 Log Books

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy and procedures that address all of the key elements of this indicator. The policies were reviewed on 11/7/14 and revised 10/24/17. The policy and procedures are signed on an annual basis and last reviewed on 10/12/2018 by the Executive Director, Clinical Director and Shelter Manager.

Lippman Youth Shelter maintains an electronic logbook that records all routine information, emergency situations, and incidents pertinent to shelter activities. The agency requires all staff to utilize the log book for the purposes of signing in and signing out. Logbook entries are reviewed by direct care staff and supervisory staff at the beginning of each shift. Electronic log book must include entries that could impact the security and safety of the youth and/or program which are highlighted. All entries should include date and time of incident, event or activity, names of youth and staff involved, a statement providing pertinent information, and the names and signature of the person making the entry. Agency should strike line through all errors in recording in the log book. The program Director should review the log book every week and make notes indicating the dates reviewed and if any correction, recommendations and follow ups are required along with signature/date of entry. All oncoming supervisor and direct care staff should review log book of previous two shifts to be aware of any unusual occurrences, and problems.

An electronic logbook was reviewed during the timeframe from October 1, 2018 through January 29, 2019. Effective communication among staff from shift to shift was well documented in the electronic logbook along with vital information such as security or safety of program and the welfare of the youth are highlighted for quick reference. The log book reflects staff reviews the logbook of the previous two shifts and that the staff is signing in and signing out on each shift. Supervisors review weekly using a red ink pen to provide information and any recommendations for staff. All entries are brief and all recording errors (documented properly) were struck with a single line noted as void and initialed.

Thorough documentation on incidents and CCC incidents that were called in as well as responses from CCC were documented in the log book. Staff also documents when client arrives in shelter and when there are discharges.

No exceptions were noted for this indicator.

### 3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a detailed written description of the Behavioral Management System (BMS) which is explained to youth at program orientation. The policies were reviewed on 11/20/14 and revised 9/21/15. The policy and procedures are signed on an annual basis and last reviewed on

10/12/2018 by the Executive Director, Clinical Director and Shelter Manager.

The agency has implemented policies and procedures regarding its BMS that is intended to not only gain compliance with program rules but to impact the youth to make positive pro-social choices and increase personal accountability and social responsibility. The program has variation of rewards (recreational outings, extra privileges), appropriate consequences, and behavioral management system which is based on a token economy of points and phrases and is used to encourage youth to decrease or eliminate negative behaviors and increase positive behaviors. Rewards outnumber consequences and therefore youth have the opportunity to earn back points that are deducted.

Lippman Youth Shelter is a hands-off facility and staff is trained in (MAB) behavioral intervention to utilize the least amount of force necessary to address the situation so that basic rights of youth are not violated.

During the interview with the Shelter Manager, the (BMS) procedure that is in place was described. In the review of three residential files, it was confirmed that staff does explain the (BMS) during program orientation and acknowledgement of resident handbook. In addition, staff documents the behavioral notes on a daily basis. Upon admission to the youth shelter, each youth receives a coping skills form where s/he writes their coping skills to use when they are angry to help manage their behavior. Also a youth is given a Daily Skill Card that is used to document points and also have the initial behavioral goal for following shelter rules. Positive behaviors are rewarded by being given points and earning different Phase Levels. While negative behavior results in receiving an EBT/LOP and no points are being given. The goal is to receive checks/points per day for good deeds behavior on their card in order to be allowed to visit the prize cabinet at the end of the week depending on the total number of points. In the cabinet there were items such as sweets/snacks, hygiene products and other supplies.

Phase levels are also a part of the reward system Lippman Youth Shelter practice. Phase work has to be completed with 1 week off of consequences in order to move up to each phase. Staff can also recommend a client be promoted a phase. All five phases work is reviewed and approved only by shelter manager.

Three new hire files were reviewed and it was observed that all staff had training on the BMS rewards and consequences. Per interview with one youth, (BMS) was mentioned during orientation and point system was explained. Youth was aware of the phases, good deeds, and level was given by staff on behaviors. The youth commented that the system is structured, fair, simple and consistent.

No exceptions were noted for this indicator.

### 3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy and procedures that address all of the key elements of this indicator. The policies were reviewed on 11/20/14 and revised 9/21/15. The policy and procedures are signed on an annual basis and last reviewed on 10/12/2018 by the Executive Director, Clinical Director and Shelter Manager.

The policy ensures the agency maintains minimum staffing and security of youth by Florida Administrative Code and contract. Staffing ratios are maintained as follows: 1 staff to 6 youth during awake hours and 1 staff to 12 youth during the sleep period. At all times there is at least one staff on duty of the same gender as the youth and should always be both male and female staff present, including the overnight or sleep period.

The staff schedule is provided to staff and posted in the staff area office. Lippman Youth Shelter (LYS) staff schedule is posted weekly (Sunday through Saturday) and a holdover or overtime rotation roster and a list of staff telephone numbers who may be accessed when additional coverage is needed is notated at the bottom of the schedule.

The shifts are 8 hours with variations of 7am-3pm, 3pm-11pm, and 11pm-7am. The staff schedules have blank fields during weekly schedule. There is ample coverage, two staff on duty even when the census has been below six youth. The schedule book is located in the Shelter Manager's office. The current and future schedule is posted in the staff room for everyone to see. There is a list of all youth care worker's names and cell phone numbers posted in the staff room and a LYS Weekly Schedules binder. After reviewing a sample size of the past three months, a lot of substitutions in coverage was made, but always stayed within ratio. The program has four vacancies currently for two fulltime and two part time youth care staff for which they are actively seeking to fill. Overall most of the shifts reviewed had both female and male staff on duty with the youth.

There is a policy for beds checks that meets the standards every 15 minute intervals during sleep hours. A review of random overnight bed checks was conducted for the following dates: 12/30/18, 12/31/18, 1/3/19, 1/19/19, 1/20/19 and 1/26/19. It was observed that two staff were on duty and all the checks aligned within the 15 minutes while youth were sleeping.

There were twelve findings within the last three months where there was no male staff coverage for the overnight shift during sleep period. The program utilized two female staff to stay in ratio. The agency indicated they made an effort to recruit male staff during these months; 2 staff were hired but were released within a week due to positive drug testing. HR also provided reviewer with current job posting to fill position.

### 3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that meets all required elements listed in the Florida Network standards for indicator 3.07. The policies were reviewed on 8/24/2016, and approved 10/12/2018 by the Executive Director, Clinical Director, and Residential Services Manager.

The agency documents procedures for Staff Secure and Domestic Violence populations; however, specific procedures for DMST and FYRAC were not maintained. LSF Southeast does not serve Probation Respite youth or provide Intensive Case Management (ICM) services and this was not indicated in policy 3.07.

Staff secure services are designed to serve court ordered youth. Referrals to staff secure shelter services must come through the court in a CINS petition per Florida Statute 984.225. Staff Secure shelter services include the following: In-Depth Orientation on Admission; Assessment and Service Planning; Enhanced Supervision and Security; Parental Involvement; and Collaborative Aftercare. Staff secure youths require a higher level of security and supervision as they exhibit more at-risk and runaway behaviors usually than average CINS youth. All staff secure youth are assigned an individual staff member on each shift in order to closely monitor their behavior and better prevent runaways. A change in staffing pattern will be evident as a staff member will be assigned to these youths on every shift for extra supervision and monitoring.

Domestic Violence Respite services are designed to serve youth that have been arrested on a domestic violence charge, are screened by the local detention center/screeners, and do not meet detention criteria and cannot immediately return home. Domestic violence placement is short term and cannot remain in shelter more twenty (21) days and are available to both male and female youth ranging from ages 10 years and up to 18 years of age who have been charged with an offense of domestic violence.

During the entrance meeting, the Executive Director stated that LSF SE does not serve Probation Respite (due to zoning restrictions) or ICM youth. At the time of the review, the agency had served only domestic violence population cases since the last QI review. Two closed residential Domestic Violence Respite files were reviewed. Delinquency face sheets were provided in files for evidence that youth were admitted DV Respite placement pending DV charges and have been screened by the JAC/Detention but do not meet criteria for secure detention. All three youth did not exceed the length of stay of 21 days for placement. No approval documentation was needed for all three cases due to youth not exceeding the 21 days in shelter and did not have to transfer into CINS/FINS bed or Probation Respite. All case plans/treatment plan reflected goals which focused on coping skills to manage anger, family coping skills, and other interventions design to reduce re-occurrence of violence in the home. All three files reviewed were consistent with the same services required for CINS/FINS population.

No exceptions were noted for this indicator.

**3.08 Video Surveillance System**

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedures that address all of the key elements of this indicator. The policies were reviewed on 8/24/16, and revised 10/24/17. The policy and procedures are signed on an annual basis and last reviewed on 10/12/2018 by the Executive Director, Clinical Director and Shelter Manager.

Lippman Youth Shelter has a video surveillance system that is instituted and in operation 24 hours a day, 7 days a week. The procedure requires that the system maintain the following capabilities:

1. Capture and retain images for a minimum of 30 days.
2. Record date, time, and location.
3. Maintain a resolution able to identify faces.
4. Cover all general areas, but not sleeping rooms or rest rooms.
5. Only accessible to designated personnel.
6. Bi-weekly supervisory review and noted in the logbook.
7. Reviews assess a random sample of overnight shifts.
8. All cameras are visible and a notice is provided that they are in use.

9. Ability to provide selected video to third party requests.

The agency has a video surveillance system with 16 cameras that backs up video in excess of 30 days. Lippman Youth Shelter video surveillance system is able to capture and retain video photographic images including facial recognition. In addition, the cameras can operate during a power outage due to support of generators. All 16 cameras were visible to the public and at the lobby entrance a sign notated surveillance system in place. All 16 cameras were positioned in the common areas but none placed in youth dorms or facility restrooms.

The Executive Program Director provided a list of designated personnel who can access the video surveillance system. A binder was provided by the Executive Program Director with logged random video review dates within the minimum once every 14 days of review of random sampling of overnight shifts.

No exceptions were noted for this indicator.

## Standard 4: Mental Health/Health Services

### Overview

#### Rating Narrative

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

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

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

### 4.01 Healthcare Admission Screening

Satisfactory
  Limited
 Failed

#### Rating Narrative

The program has written policy regarding healthcare admission screening approved, reviewed, signed and dated by the Executive Director, Clinical Director and Shelter Manager on October 12, 2018. The program policy meets the requirements of the key indicator.

The procedure requires each youth receive a physical screening by a program nurse at time of admission by completing the CINS/FINS Intake Assessment form. The preliminary screening includes all the required elements. The non-health staff may perform this screening when a nurse is not available for this screening. At intake the youth and parent/guardian are required to sign consent forms that clearly defines specific responsibilities for medications and any form of medical treatment. The program procedures include a thorough referral process and a mechanism for necessary follow-up medical care. All the program staff will receive general training in assessing common health conditions and risks. In all applicable cases the notification to the parents/guardians is required whenever a medical condition is reported to or diagnosed by the program staff. Observations for evidence of injury, illness, physical distress, difficulty moving, scars, tattoos, or other skin markings are documented. In addition, all medical referrals are documented on a daily log.

Healthcare Admission Screening forms were completed as required in the three active youth records reviewed. Health care screenings included: current medications; existing medical condition (acute and chronic); allergies; recent injuries or illnesses; observation for evidence of illness, pain, physical distress, difficulty moving etc.; and observation for presence of scars, tattoos, or other skin markings. None of the youth files reviewed indicated youth had a chronic medical condition that needed an immediate referral.

No exceptions were noted for this indicator.

### 4.02 Suicide Prevention

Satisfactory
  Limited
 Failed

#### Rating Narrative

The program has written policy and procedures regarding suicide prevention that includes a mental health, substance abuse, and suicide risk plan, approved, reviewed, signed and dated by the Executive Director, Clinical Director and Shelter Manager on October 12, 2018. The program policy meets the requirements of the key indicator.

The program has a written mental health, substance abuse, and suicide risk plan in place that was reviewed. The program procedure requires all youth being admitted to the shelter be assessed for suicidal risk utilizing the CINS/FINS Intake Assessment. The program assessment was approved by the Florida Network of Youth and Family Services. If a youth answers yes to any of the suicide risk questions staff immediately call the clinical services manager or the residential program manager for further instructions. Youth is placed on sight and sound and this is documented in the alert log book and the daily log book. Youth also needs to be evaluated by a licensed mental health clinician within 24 hours. Once the suicide risk assessment is completed youth is either be sent to the general population or placed on elevated supervision, sight and



sound or placed on one-to one precautions while awaiting Baker Act. All elevated supervision must be documented as required. The medical/mental health alert binder and the daily log is to be reviewed weekly by the shelter manager and daily at shift change for each shift supervisor.

Suicide Risk Screening and Precautionary Observation Log forms were completed as required in the three active youth records reviewed. Practice indicates the program is in compliance with all contracted obligations for the screening and response to youth at risk of suicide. All screenings and assessments were conducted according to the required time frames and utilizing the approved tools. The screening results were reviewed and signed by the licensed supervisor and documented in the youth's case file in all 3 files. Similarly, the youth were placed on sight and sound supervision until assessed and removed by the licensed professional. Observation logs indicate 30 minute supervision intervals by designated staff.

No exceptions were noted for this indicator.

#### 4.03 Medications

Satisfactory

Limited

Failed

##### Rating Narrative

The program has written policy and procedures regarding medications approved, reviewed, signed and dated by the Executive Director, Clinical Director and Shelter Manager on October 12, 2018. The program policy meets the requirements of the key indicator.

Medications are stored in a Pyxis Med-Station 4000 Medication Cabinet located in the medication room, inaccessible to youth. The program needs to maintain a minimum of two super users for the med-station. The program does not accept youth currently prescribed injectable medications, except for epi-pens.

A tour of the program and observation found the program has a Pyxis Med-Station 4000 Medication Cabinet located in the medication room. The program has a list of eleven staff members and a list of two part-time registered nurses (RNs) that has been authorized to assist in the distribution of medication. Four staff members and the 2 part time nurses are assigned as Super Users for the Med-Station. Documentation review and staff interviewed indicated the program does not have any narcotics. There was one youth on control medication and it was stored on the Med-Station in the medication room behind two locks and documented in the medication distribution log. A perpetual inventory with running balance was maintained. All the youth's Medication Distribution Logs (MDLs) reviewed displays the required information. Observation of the medication room found the program has a small refrigerator used to store medication that was empty at the time of the review. There were no syringes and sharps at the program at the time of the review. Documentation reviewed confirmed the program had a medication disposal binder and a medication disposal form that documented the program disposed three medications during the review period. Interviews conducted with the executive director and the program director indicated when youth is discharge youth/family owned OTCs are returned to the parents/guardians with the youth personal items.

Not all unlicensed staff have had epi-pen training provided by a registered nurse. Training was verified for 3 current youth care staff. The most recent Epi-pen training was conducted in August 2017.

#### 4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

##### Rating Narrative

The program has policy and procedures regarding the Medical/Mental Health Alert process approved, reviewed, signed and dated by the Executive Director, Clinical Director, and Shelter Manager on October 12, 2018.

The policy ensures information concerning youth's medical condition, physical activity restrictions, allergies, common side effects of prescribed medication, foods and medication contraindicated, and other applicable treatment information is communicated to all staff. Staff is provided with sufficient training, information and instructions that allow them to recognize and respond to the need for emergency care and treatment because of identified medical or mental health problems.

The procedure requires the development and implementation of a medical and mental health alert system that communicate essential medical conditions and health related issues between the staff in the program. In addition, the procedure requires all staff to receive training in the alert system and to act to place applicable youth under heightened supervision if there is a concern for their safety. The program system includes a color code system utilized for medical and mental health alerts, youth records and precaution logs. This information is of critical importance and will be made a priority for all direct care staff and on-site administrators. All staff conducting preliminary health screening will immediately notify the counselor or assigned case worker of any medical, dental, or mental health issues or needs. Staff needs to utilize all possible means of communication at their disposal to ensure effective communication of medical and/or mental health issues. This may include, but not to be limited to, the preliminary health screening, program log, shift change form, the alert system, case progress notes and other forms of program communication, including notifying the on-call counselor or the shelter manager after hours.

In practice, the shelter Youth Care Specialist and/or assigned counselor completes the initial intake with each youth to determine and document

youth medical condition, mental health or substance abuse issues and needs that requires immediate attention. Any condition noted is documented on the medical and mental health alert board located in the intake office as well as the food allergy board located in the kitchen, when applicable. The review of three active youth records randomly selected found that each youth was appropriately placed on the program's alert system. The review of the program's alerts included the review of applicable precautions concerning the medications prescribed. When youth's condition needs to be handled immediately staff contact the parent or legal guardian at once to come and provide the appropriate medications or care that the youth may need. The review of the program's food allergy board found it was up-date as needed and listed three youth on special diet/nutritional needs, at the time of the review.

No exceptions were noted for this indicator.

#### 4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

##### Rating Narrative

The program has policy and procedures regarding Episodic/Emergency Care approved, reviewed, signed and dated by the Executive Director, Clinical Director, and Shelter Manager On October 12, 2018.

The policy dictates procedures for obtaining off-site emergency services and the subsequent reporting and aftercare responsibilities. The program procedures ensure the provision of emergency medical and dental care and require that all direct care staff be trained and certified in first aid and cardiopulmonary resuscitation (CPR) procedures within six months of beginning work with youth and are retrained as required. The procedures also require that all shelter staff be trained on the use of the knife for life and the location of the First Aid kits prior to direct work with youth in the shelter. In addition, the procedures require the program prominently display emergency telephone numbers including 9-1-1 and Poison Control numbers. Any emergency medical care administered to youth in the shelter needs to be documented in the youth's individual record with outcomes and resolution.

In practice the program has two main first aid kits in the building and single kits in each of the three vehicles. All the first aid kits in the program and each vehicle were revised and up-to date by a CINTAS representative the second day of this review. The program maintains an episodic/emergency care binder that was reviewed. The review of the past six months CCC Daily Reports found there were several incidents of episodic/emergency care documented and in the majority the program notified the parents/guardians who transported youth to and from the hospital, doctors, or dentists. The review of the program's emergency drill binder confirmed they were conducted as required, at different times of the day and with different medical scenarios each time. Each emergency drill reviewed documented who was present, how they responded, procedures performed and outcome. The program's youth and parent/guardian orientation handbook contained emergency procedures.

No exceptions were noted for this key indicator.