Florida Network for Youth and Family Services
Compliance Monitoring Report for

Lutheran Services Florida Southeast
Lippman Youth Shelter

221 NW 43rd Court
Oakland Park, Florida 33309

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Introduction

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for Lutheran Services Florida Southeast (LSF Southeast), for its FY 2019-2020 CINS/FINS contract, on February 5-6, 2020. The review was conducted at the program's two locations: 1) Lippman Youth Shelter located at 221 NW 43rd Court, Oakland Park, Florida, and 2) Administrative office located at 4185 North State Road 7 in Lauderdale Lakes, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. LSF Southeast is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance, and are funded with General Revenue Funds effective for July 2019 through June 30, 2020.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC and Peer Reviewers. Agency representatives from LSF Southeast present for the entrance interview were: Raymond Ballinger, Executive Director; Scoundrel Oliver, Shelter Manager; Kali Fabal, Clinical Director; Ivonne Fusco, Executive Administrative Assistant; and Laura Saldana, Outreach Liason. The last onsite QI visit was conducted January 28-29, 2019.

In general, the Reviewer found that LSF Southeast is in compliance with specific contract requirements. LSF Southeast **received an overall compliance rating of 100% for achieving full compliance with all thirteen (13) indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions or recommendations made as a result of the monitoring visit.

The following report represents the results of the in-depth evaluation of the provider's General Administrative performance, with all findings clearly documented. Copies of all completed tools utilized during the visit to determine these ratings will be maintained on file with the Reviewer. If any information or clarification is required, please contact Keith Carr by E-mail: keithcarr@forefrontllc.com

2019-2020 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 2-05-2019-2020

Agency Name: Lutheran Services Florida Southeast	**Monitor Name: Marcia Tavares**
Contract Type : CINS/FINS	**Region/Office: 221 NW 43 Ct., Oakland Park, FL 33309**
Service Description: Comprehensive Compliance Monitoring I	**Site Visit Date(s): February 5-6, 2020**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	The provider currently has three (3) certified DJJ-QI Peer Reviewers: Raymond Ballinger; Kali Fabal; and Ivonne Fusco. Both Mr. Ballinger and Ms. Fabal have participated in QI Peer Reviews during the current FY.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: A list of three additional contracts, Childcare Food Program, ChildNet, and HHS for FY2019- 2020 was provided. The list includes: awarding entity, amount funded, type of service provided and award term. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation	☐	☐	☐	☒	☐	General Liability through Markel Global Insurance Company, for limits of coverage $1,000,000 each $3,000,000 aggregate, and medical expense for	

Agency Name: Lutheran Services Florida Southeast	Monitor Name: Marcia Tavares
Contract Type : CINS/FINS	Region/Office: 221 NW 43 Ct., Oakland Park, FL 33309
Service Description: Comprehensive Compliance Monitoring I	Site Visit Date(s): February 5-6, 2020

Major Programmatic Requirements	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						$10,000, effective 6/01/2019 – 6/01/2020. Automobile insurance through Markel Global Insurance Company for combined limits of liability/property damage for $1,000,000. Policy effective date 6/01/2019 – 6/01/2020. Workers Compensation through Accident Fund Insurance Company of America with limits of $1,000,000 each/aggregate, effective 6/01/2019 – 6/01/2020. Umbrella liability through Markel Global Insurance Company with limits of $5,000,000 each/aggregate, effective 6/01/2019 – 6/01/2020. Professional Liability/Abuse Molestation through Markel Global Insurance Company for $1,000,000 each and $3,000,000 aggregate, effective through 6/01/2019 – 6/01/2020. Florida Network is listed as certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☒	☐	☐	During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by any external funding source.	

Agency Name: Lutheran Services Florida Southeast	**Monitor Name: Marcia Tavares**
Contract Type : CINS/FINS	**Region/Office: 221 NW 43 Ct., Oakland Park, FL 33309**
Service Description: Comprehensive Compliance Monitoring I	**Site Visit Date(s): February 5-6, 2020**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures. Agency maintains an Accounting Procedures Manual that is consistent with GAAP and provide for limited internal controls. Policies and procedures were last approved 11/13/14 by the Executive VP/CFO and VP of Finance and are updated as necessary with revised policies showing a revision/approval date.	
b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: Expanded General Ledger – Detail GL for July 1, 2019 – December 31, 2019. The agency maintains a detailed general ledger with corresponding source documents. General ledger is structured to track all funding sources and there is a separate GL for the Lutheran Services Florida Southeast CINS/FINS program.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (disbursements/invoices are approved & monitored by management). –**ON SITE**	☐	☐	☒	☐	☐	Observation/Documentation: Reviewed petty cash Policy and Procedure included in the Fiscal Manual. There are two separate funds, one for the Nonresidential program ($500) and the other for the shelter which does not exceed $1000. Petty cash is maintained by the Administrative Assistant (Non-Res) and the Residential Manager (Shelter) and are stored in secured cash boxes. Petty cash is reconciled at least monthly by the custodians, approved by	

Agency Name: Lutheran Services Florida Southeast	Monitor Name: Marcia Tavares
Contract Type : CINS/FINS	Region/Office: 221 NW 43 Ct., Oakland Park, FL 33309
Service Description: Comprehensive Compliance Monitoring I	Site Visit Date(s): February 5-6, 2020

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
						management, and submitted to the corporate office for refunding as needed. Disbursements and invoices are approved by the program manager or designee.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation: Reviewed Bank Statements for Bank of America Bank's operating account and the corresponding Bank Reconciliations for the period July-December 2019. Bank reconciliations are processed by the finance department in the Tampa Corporate office. Successful bank reconciliations were conducted within 2 weeks of receipt of bank statements. All of the reconciliation worksheets were reviewed by a second party in addition to the preparer. Vendor payments are distributed through the corporate office in Tampa, Florida through check requisitions by the Broward office. Vendor files are maintained locally with copies of the invoices and check requisitions.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Provider maintains an inventory for computer and periphery equipment purchased from 12/2002. Inventory was last updated on 1/29/20 but no	

Agency Name: Lutheran Services Florida Southeast	Monitor Name: Marcia Tavares
Contract Type : CINS/FINS	Region/Office: 221 NW 43 Ct., Oakland Park, FL 33309
Service Description: Comprehensive Compliance Monitoring I	Site Visit Date(s): February 5-6, 2020

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
						additional items were purchased with FN funds within the last year.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: ADP is contracted by LSF to process payroll. ADP is responsible for submitting information for W2s, Quarterly 941 reports, and payroll taxes. ADP Tax Ledger Deposit Details for April 1, 2019 -September 30, 2019 and reconciliation details for the 3rd Qtr 2019 were reviewed. These reports demonstrate submission of payroll taxes and deposits biweekly.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Statement of Revenues and Expenditures for FY to date as of 12/31/19 for the CINS/FINS Program was reviewed. A program surplus was observed per the statement. The provider has a monthly process for reviewing and explaining variances.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: The provider submitted a copy of the Financial audit conducted for year ending June 30, 2019 and 2018 for the review. The audit was completed by RSM US, LLP and was dated December 26, 2019. No management letter was stated as issued in the audit.	

Agency Name: Lutheran Services Florida Southeast	**Monitor Name: Marcia Tavares**
Contract Type : CINS/FINS	**Region/Office: 221 NW 43 Ct., Oakland Park, FL 33309**
Service Description: Comprehensive Compliance Monitoring I	**Site Visit Date(s): February 5-6, 2020**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation of policy and procedures regarding data back-up contained in the Agency P&P Section 2.10, on Information Management. Policy and Procedure number: 9.5.01 (Case Records) and G11.4 (Confidentiality of Client Information). Laptops are not furnished to case workers.	

CONCLUSION

LSF Southeast has met the requirements for the CINS/FINS contract as a result of full compliance with all thirteen (13) indicators of the Administrative and Fiscal Contract Monitoring Tool. Consequently, t**he overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited or recommendations made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, all of the indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

If applicable, the provider must submit a corrective action plan to address the Corrective Action cited in the corresponding section of this report. The provider's Corrective Action Plan should address the issues, corrective actions item cited, time frames and staff responsible. Responses to items cited for corrective actions are due to the Florida Network and the Florida Network Contract Manager within fourteen (14) working days of receipt of this report (See Florida Network Site for the Service Provider Corrective Action Form). The Florida Network Contract Manager will then review the response to the corrective action(s) to determine if the response adequately addresses the problem identified in the report within three (3) days. Upon approval the provider will then implement the approved measure to address the item(s) cited in the report. If the corrective action is successful in resolving the items cited in the report the contract monitor will notify the Provider in writing that the desired resolution has been achieved. Log on to the Florida Network (www.floridanetwork.org) website forms section and download the Service Provider Corrective Action Tracking Form. Recommendations made are suggestions regarding fiscal issues observed during the review. These items do not necessarily require a written response.

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Lutheran Services Florida Southeast
Lauderdale Lakes, Florida
Lippman Youth Shelter Program

February 5-6, 2020

Compliance Monitoring Services Provided by

FOREFRONT

Quality Improvement Review

Lutheran Services Florida Southeast – February 5-6, 2020
Lead Reviewer: Marcia Tavares

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 85.71%
Percent of indicators rated Limited: 14.29%
Percent of indicators rated Failed: 0.00%

Standard 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 & 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
2.09 Special Populations	Satisfactory
2.10 Stop Now and Plan (SNAP)	N/A

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 & Special Populations

3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 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 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%

Overall Rating Summary
Percent of indicators rated Satisfactory: 96.30%
Percent of indicators rated Limited: 3.70%
Percent of indicators rated Failed: 0.00%

Rating Definitions

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

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or 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.

Reviewer

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services

Keith Bennis- Department of Juvenile Justice

Kelly Barnett – Children's Home Society WaveCREST

Lashonda Chavis - Miami Bridge Youth and Family Services

Christi Shortes – Florida Keys Children Shelter

Quality Improvement Review

Lutheran Services Florida Southeast – February 5-6, 2020
Lead Reviewer: Marcia Tavares

Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care, and (4) Mental Health/Health Services which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2019).

Persons Interviewed

- ☐ **Chief Executive Officer**
- ☐ **Chief Financial Officer**
- ☒ **Program Coordinator**
- ☐ **Direct – Part time**
- ☐ **Volunteer**
- ☒ **Clinical Director**
- ☒ **Counselor Non-Licensed**
- ☐ **Advocate**
- ☐ **Nurse – Full time**
- ☐ **Executive Director**
- ☒ **Program Director**
- ☒ **Direct – Care Full time**
- ☐ **Direct – Care On-Call**
- ☐ **Intern**
- ☐ **Counselor Licensed**
- ☒ **Case Manager**
- ☒ **Human Resources**
- ☒ **Nurse – Part time**
- ☐ Chief Operating Officer
- ☒ Program Manager
- **1** # Case Managers
- **2** # Program Supervisors
- **0** # Food Service Personnel
- **0** # Healthcare Staff
- **0** # Maintenance Personnel
- **N/A** # Other (listed by title): _____

Documents Reviewed

- ☐ Accreditation Reports
- ☒ Affidavit of Good Moral Character
- ☒ CCC Reports
- ☒ Logbooks
- ☒ Continuity of Operation Plan
- ☐ Contract Monitoring Reports
- ☐ Contract Scope of Services
- ☒ Egress Plans
- ☒ Fire Inspection Report
- ☐ Exposure Control Plan
- ☒ Table of Organization
- ☒ Fire Prevention Plan
- ☒ Grievance Process/Records
- ☐ Key Control Log
- ☒ Fire Drill Log
- ☒ Medical and Mental Health Alerts
- ☒ Precautionary Observation Logs
- ☒ Program Schedules
- ☒ Supplemental Contracts
- ☐ Telephone Logs
- ☒ Vehicle Inspection Reports
- ☐ Visitation Logs
- ☒ Youth Handbook
- **4** # Health Records
- **4** # MH/SA Records
- **18** # Personnel /Volunteer Records
- **9** # Training Records
- **11** # Youth Records (Closed)
- **9** # Youth Records (Open)
- **_** # Other:

Surveys

- **3** # Youth
- **3** # Direct Care Staff
- **0** # Other: _____

Observations During Review

- ☐ Intake
- ☒ Program Activities
- ☐ Recreation
- ☐ Searches
- ☒ Security Video Tapes
- ☒ Social Skill Modeling by Staff
- ☐ Medication Administration
- ☒ Census Board
- ☒ Posting of Abuse Hotline
- ☒ Tool Inventory and Storage
- ☒ Toxic Item Inventory and Storage
- ☐ Discharge
- ☐ Treatment Team Meetings
- ☐ Youth Movement and Counts
- ☒ Staff Interactions with Youth
- ☒ Staff Supervision of Youth
- ☒ Facility and Grounds
- ☒ First Aid Kit(s)
- ☐ Group
- ☒ Meals
- ☒ Signage that all youth welcome

Comments

Additional Comments regarding observations, other important findings of interest, etc.

Strengths and Innovative Approaches

Rating Narrative

Lutheran Services Florida is a statewide, non-profit, human services agency with its headquarters located in Tampa, Florida. LSF Southeast (LSF SE) contracts with the Florida Network of Youth and Family Services (Florida Network) to operate Children In Need of Services/Families In Need of Services (CINS/FINS) residential and non-residential services to youth and families in Broward County. The program operates out of two locations: 1) the Lippman Youth Shelter, located in the City of Oakland Park, Florida, and, 2) the administrative office and 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. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The agency also provides services to special populations who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking (DMST), and youth referred by the Juvenile Justice Court System for domestic violence respite. LSF SE is not currently contracted to provide Probation Respite, Intensive Case Management, or Family and Youth Respite Aftercare services (FYRAC) and is not a SNAP provider.

Lutheran Services Florida was accredited by the Council on Accreditation (COA) in 2005 and has consistently maintained re-accreditation effective through February 28, 2022. During the past year, LSF had several changes in leadership.

- In June 2019, the former shelter manager of Oasis youth shelter in the southwest region was promoted to Executive Director of Programs for the southeast region
- Two new master's level counselors were hired for the Lippman Youth Shelter in June and October 2019
- The vacant shelter manager position was filled in October of 2019 with a candidate who has proven to be a strong leader and has helped boost morale at the shelter
- A new counselor was hired for the non-residential program in September 2019

Under the leadership of the clinical director, Lutheran Services Florida SE Continues a very vibrant and rewarding internship program. The clinical director currently supervises four interns and one of the former interns is currently employed as a counselor at Lippman Youth Shelter.

On October 6, 2019, Chase Bank chose Lippman Youth shelter for their day of caring. There were more than 30 Chase employees at Lippman painting the youth bedrooms.

Inspired by the day of caring and the efforts of the volunteers, staff from the administrative office as well as program staff convened to paint and redecorate the lobby two weeks later. The entire shelter has since been painted.

In January of 2020, LSF SE partnered with Boys Town to provide parenting classes for clients utilizing Boys Town's "common sense parenting" curriculum.

Note Active/Electronic logbook continues to be utilized as the program's system of record for daily activity to achieve higher levels of documentation in the digital logbook platform.

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: a program director; a shelter services manager; a licensed clinical director; and a senior administrative assistant. At the time of the review, the program had one vacant full-time youth care position and one non-residential counselor.

Since the last QI visit the agency has made changes in leadership for the southeast region as well as the shelter manager's position. Mr. Ballinger was promoted in June 2019 from shelter manager of the Oasis Fort Myers program to program director of the southeast region. Additionally, the shelter manager's position was vacated in January 2019 and was filled in October 2019. Apart from the administrative changes mentioned above, the program has not reported any major challenges, incidents, administrative review, or current external investigation.

The program assigns individual staff as chairpersons to represent committees responsible for the collection of various data required by the indicator. 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 in 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.

The following indicators in standard 1 were rated satisfactory with exceptions: 1.02-Provision of an Abuse Free Environment; 1.04 –Training Requirements; 1.05 – Analyzing and Reporting Information; and 1.06 – Client Transportation. Indicator 1.03 – Incident Reporting received a "Limited" rating. All other indicators in standard one were rated satisfactory with no deficiencies.

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. 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. 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.

Broward Family Center community-based program offers both school and home-based services that are divided between four (4) full time counselors (2 bachelor's level, 1 master's level, and 1 vacant position) under the supervision of a licensed (LCSW) clinical director. The counselors are responsible for providing case management services and linking youth and families to community services. The community-based services span the entire Broward County.

LSF SE non-residential program does not provide Intensive Case Management (ICM), Family and Youth Respite Aftercare Services (FYRAC), or probation respite services. At the time of the review the program had not served any staff secure or domestic minor youth. However, the program has provided domestic violence services. The agency is currently maintaining paper files and youth records are maintained in a neat and orderly manner including typed needs assessments.

The only indicator in standard 2 rated satisfactory with exception is 2.05 – Counseling Services. Indicator 2.10 – SNAP is not applicable as LSF SE is not a SNAP provider. All other indicators in standard two were rated satisfactory with no deficiencies.

Standard 3: Shelter Care

Overview

Rating Narrative

LSF Southeast operates its residential program, Lippman Youth Shelter, in Oakland Park, Florida. The shelter is licensed by the Department of Children and Families (DCF) for 20 beds through 6/27/2020. The shelter provides residential services to youth in the Department of Juvenile Justice (DJJ) CINS/FINS program as well as youth referred by Child Net, the lead case management organization for DCF.

The shelter program staff structure includes: a Shelter Services Manager, a Youth Care Supervisor (YCS III), one YCS II, 9 fulltime YCS I, and eight temporary YCS I. In addition to the Clinical Director, the residential clinical component includes two master's level counselor positions.

A tour of the facility revealed that it has a clean and well-maintained facility with adequate accommodations for the clients which include bed linens and separate beds in each room, adequate furnishings, clean functional bathrooms and adequate lighting. The youth lounge has comfortable sofas for youth to sit and relax. Next to the youth lounge is the observation area where the staff is stationed to monitor youth movement and activities. There are schedules generated for weekly activities and weekly school schedules. Several facility improvements were observed during the tour. In partnership with Chase Bank, all the bedrooms were freshly painted and adorned with new colorful comforters. The décor throughout was home-like and decorative. The addition of chalk-walls in the dining room, group room, and some doors give youth the opportunity to visually express themselves positively and creatively. Similarly, the exterior was well-maintained and nicely landscaped.

This year, the Lippman youth shelter program adopted the Boys Town behavior management system. The behavior management system is based on a token economy of points and phase levels, and is used to encourage youths to decrease or eliminate negative behaviors and to increase the positive behaviors. Upon admission the Lippman Youth Shelter, each youth receives a coping skills form where the client writes their coping skills to use when they are angry to help manage their behavior. Positive behaviors are rewarded by being given points and earning different Phase Levels. While negative behaviors result in receiving an early bedtime/loss of privilege (EBT/LOP), no points are being given. The goal is to receive points per day for good behavior on their card in order to be allowed to visit the incentive closet at the end of the week depending on their total number of points. 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. All phase work is reviewed and approved only by shelter manager. Consequences for violation of program rules are applied logically and consistently. When a youth behaves in a negative manner the staff re-directs youth or offers youth to take regroup/time away from the group to review their coping skills. If the behavior continues, youth will be given an EBT or LOP depending on the severity of the behavior. Also, staff will explain the reason why the youth was given the consequence.

The following two indicators in standard 3 were rated satisfactory with exceptions: 3.01-Shelter Environment and 3.03 – Room Assignment. All other indicators in standard three were rated satisfactory with no deficiencies.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The residential counseling services in the shelter are overseen by a Licensed Clinical Social Worker who serves as the clinical director. Designated trained youth care coordinators complete screening and the CINS/FINS Intake assessment during intake. All direct care staff members are trained on the suicide risk screening process and utilize the CINS Intake form to immediately identify 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 licensed clinical professional is notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented on the alert board that is discreetly posted in the YCSIII's office and in the youth's file using a color-coding dot system.

At the time of the QI review the provider had a licensed part time registered nurse (RN) contracted to provide services on-site. The duties assigned to the registered nurse includes: oversight of the general practice of distributing medication to residents in the shelter; oversight of medication inventory and storage practices; training of all staff authorized to distribute medication; and completion of health screenings and medical follow ups on an as needed basis. All training files reviewed onsite supported staff maintained valid CPR/First Aid training certificates.

During the tour of the facility, medications were observed to be stored in a locked room in their own separate containers in client specific drawers in the Pyxis Med Station 4000. Topical medications are stored separately from oral medication. The program has a list of staff who are authorized to distribute medication including super users. Medication records for each youth are maintained in the youth's file.

The program maintains 39 written agreements with other community partners which include medical and mental health services and a comprehensive referral process.

The following two indicators in standard 4 were rated satisfactory with exceptions: 4.03-Medications and 4.05 – Episodic/Emergency Care. All other indicators in standard four were rated satisfactory with no deficiencies.

STANDARD 1: MANAGEMENT ACCOUNTABILITY

Quality Improvement Indicators	Rating: Satisfactory	Rating: Explain: Deficiency Identified	Rating: Explain: No Eligible Items For Review	Rating: Explain: No Practice	Rating: Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
Standard One – Management Accountability							
1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						☐ YES ☒ NO (explain) The agency has a policy 1.01 for background screening that meets most of the requirement of the indicator. The policy was last reviewed 12/12/19 and approved by the Executive Director on 1/28/2020.	The current policy 1.01 addresses the use of the Predictive Index as the pre-employment suitability assessment used prior to hire and determine suitability; however, the policy does not include a pass rate established by the program to determine threshold for hire. Upon notification, the Executive Director updated policy 1.01, effective 2/5/2020 to include the pass score of 5 and higher on the Predictive Index.
RATING	☒	☐	☐	☐	☐	A total of eighteen (18) background screening files were reviewed for ten (10) new hires, three (3) volunteers/interns, and five (5) staff that were eligible for a five-year re-screening as of the most recent QI review conducted on January 29, 2019. All ten (10) new hires were screened and received an eligible screening result prior to their hire dates. Similarly, the three (3) volunteers/interns utilized by the provider during the review period were background screened with eligible screening results obtained prior to their volunteer start dates. Proof of the	No exception.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						new employee's employment authorization from the Department of Homeland Security was obtained through E-verify and filed in the personnel file for all of ten new hires. Additionally, the five (5) staff that were eligible for five-year re-screenings 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 16, 2020 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 six (6) applicable new staff during the review period. All six employees obtained overall scores greater than/equal to 8 on a scale of 1-10. The provider's policy as of the date of the	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						onsite visit did not specify the passing rate but the Executive Director indicated the preferred score is greater than 7.	
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						☒ YES ☐ NO The agency has a policy 1.02 for Provision of an Abuse Free Environment that meets the requirements and was approved by the Executive Director (ED) on 1/28/2020.	
RATING	☐	☒	☐	☐	☐	The agency has a code of conduct that prohibits that use of physical abuse, profanity, threats or intimidations. All staff signs a code of conduct form during the orientation process. There were four personnel files reviewed and all files had the code of conduct form signed and completed. The agency has signage to reflect that all youth are accepted (regardless of sexual orientation, gender identity, or gender expression etc. During tour it was observed that the agency has signage with the pride rainbow colors on posters and stickers. The agency has posting of the Abuse Hotline Numbers in each bedroom located in the binders posted on the wall. The agency has a process in place for documenting any abuse hotline calls. Agency has a child abuse and Neglect	**Exception** Five (5) out of six (6) grievances were not signed by the staff or management, indicating the grievances were reviewed. Two (2) of the grievances were not written on an agency grievance form but on notebook paper. No documentation from the management team was provided regarding the resolution of all six grievances. During a tour of the facility it was observed that grievance forms were not available underneath the grievance box for youth to have access. This deficiency did not result in an exception: Two of the 15-child abuse and neglect report forms reviewed were missing staff name and signature.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						report form log and child abuse and neglect report form that is completed once an abuse call is made. Three files were reviewed and all files had the child abuse and neglect report form included. During the past months, the agency has had 15 abuse/neglect allegations reported and all documentation forms were completed with identified information, family data, case information, and reporter information. The agency has a grievance procedure in place and a grievance form that has been developed to report complaints. Agency has a locked grievance box in the common area for youth to place grievance forms once completed. There were six (6) grievances in the last six months. Out of the six grievances, five (5) were grievances from a client regarding a staff and one client on client grievance. Although the agency has a procedure to handle grievances in place, it was not clear on how the management team resolved the complaints. According to the agency policy, the program Manager is to review grievance within 24 hours when possible and within 72 hours the program administrator will handle the grievance; there has been no findings of any management resolutions. Grievance forms	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						are kept up to a year in a file folder in the Shelter Director's office. During the review, there were three (3) staff and three (3) shelter youth survey completed. On one of the staff surveys, question #5 was answered "No" to the question of "Do you report any knowledge or suspicion that a child is abused, abandoned, or neglected by a parent or guardian". Out of the three staff surveys, all staff stated that shelter is in good working condition and they have been trained in child abuse reporting. All three youth surveys reported that the abuse hotline is available to them although one of the youths did not know where the abuse hotline was located. All three-youth stated that adults were respectful when talking to them and other youth and all youth felt safe in shelter.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						☒ YES ☐ NO The agency has a policy 1.03- Incident Reporting that meets the requirements for the indicator and was approved by Executive Director on 1/28/2020.	
RATING	☐	☒	☐	☐	☐	A total of nine (9) incidents that were accepted by CCC were reviewed. Out of the nine CCC reported incidents, three (3) were medical incidents, three (3) youth behavior incidents, two (2) program disruption incidents, and one (1) abscond	**Exception (Limited rating)** Six (6) out Nine (9) DJJ CCC incident reports accepted were not called within two (2) hours.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						incident. All incidents were reported to CCC that were required but there were six (6) that were not called within two (2) hours of program learning about the incident. The agency has the CCC number posted in the common area where the youth resides. The agency completes follow up communication tasks/special instructions as required by CCC. Three (3) of the nine (9) accepted incident reports required follow up and email correspondence with CCC was provided. Agency has an incident log binder and incident report binder. Agency has reporting forms which are called Incident Reporting Cover Sheet, Incident report form, and an incident follow up form. All incident reports were reviewed and signed by supervisors/director. Abuse log/reports also were reviewed if there was an abuse report called due to incident. The program log book was reviewed.	One out of nine DJJ incidents accepted by CCC was not logged in the E-logbook by staff
1.04: Training Requirements **Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						☒ YES ☐ NO (Explain) The agency has a policy 1.04 for Training requirements that meets the requirement of the indicator. Policy was last reviewed on 8/19/2016 and was approved by the Executive Director on 1/28/2020.	
RATING	☐	☒	☐	☐	☐	During the review of four (4) training files for first year staff, all required training	**Exception**

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						were completed in the first 120 days of employment. There was one (1) employee still pending the training for Serving LGBTQ and Human Trafficking, but still has time to complete before the anniversary date. All 4 staff had exceeded the 80 annual training hours required. During a review of four (4) in-service employee files there were two (2) employees who did not complete two of the required trainings (Fire safety and Sexual Harassment). One employee has 37.5 hours and has until 2/15/2020 to complete the required forty hours. During the review, there were also two (2) non-licensed mental health clinical shelter staff files reviewed and both files contained the Assessment of Suicide Risk training and documentation. One file training reviewed out of the two needed one more Suicide assessment to complete but date of hire was 10/7/2019 and there is still time to meet requirements of the indicator.	One (1) out of the four (4) in service training files reviewed documented 21 training hours and the employee's anniversary date was 1/29/19. This employee had not completed the forty hours required annually.
1.05: Analyzing and Reporting Information **The program collects and reviews several sources of information to identify patterns and trends. Program should have sample reports of aggregated data and committee/workgroup minutes analyzing information.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						☒ YES ☐ NO (explain) The program has a written policy and procedures 1.05 for Analyzing and Reporting Information which was last	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						reviewed 12/12/2019 and approved on 1/28/2020 by the Executive Director. 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.	
RATING	☐	☒	☐	☐	☐	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. P&P #1.05 does not outline the specific procedures in place for analyzing and reporting data, they are documented in the agency's PQI plan. The program assigns individual staff as Chairpersons to represent committees responsible for the collection of various data required by the indicator. A formal list was not maintained but the residential and non-residential program managers provided the names of the Chairs to the Reviewer onsite. The Chairs are responsible for collecting data from the programs on a monthly basis for	**Exception:** It was observed that the shelter program has not been completing/entering the NetMIS client satisfaction surveys as zero was found to be in the FN Netmis report for 2019 through current. This is a FN requirement. The program does require youth to complete an agency consumer survey and that practice was evident.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						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 weekly in the residential program and at least monthly for non-residential files. For the period July-December 2019, a review of case record reviews demonstrated the residential program completed reviews of 4 cases each month (20 for the period).	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						The non-residential program conducted monthly case record reviews of a total of 27 files between July and October 2019 but none in the months of November and December 2019. This satisfies the quarterly peer review QI requirement but not the agency's monthly requirement. Documentation includes the checklists used during the peer record review for each file reviewed as well as a summary cover sheet that identifies deficiencies. 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 the programs statewide as well as regionally 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 2019. 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,	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						accidents and grievances are reviewed at staff meetings. A review of the agendas for monthly staff meetings held since July 2019 showed evidence of discussion of incidents/accidents and grievances during the review period. There were no incidents, accidents, or grievances reported by the non-residential program during the period. The residential program reported 10 grievances and 41 incidents for the same period. The trends and types of incidents are discussed during the staff meetings. 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 an average customer satisfaction level of 92.5% for 71 consumers surveyed and the non-residential program reported a 99% satisfaction rate. A review of the agendas for monthly staff meetings held since July 2019 showed evidence of discussion of client satisfaction surveys during the six months reviewed. The provider has established program outcomes and collects performance measures data monthly on the PQI Monthly Spreadsheet Companion Report	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						by program. Data collected includes benchmarks and performance measures such as: client satisfaction; client functioning; staff turnover; incidents/accidents; grievances; care days; data entry; service completion and status at discharge, 30 and 60-day follow-up; and exits. PQI, outcomes, and NetMIS data is reviewed and discussed at monthly staff meetings and monthly management meetings and are documented in the meeting minutes.	
1.06: Client Transportation **Policy is established to avoid situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						☒ YES ☐ NO (Explain) The agency has a policy 1.06 for Client Transportation that meets all requirements for the indicator. The policy was last been reviewed on 10/2/2018 and approved on 1/28/2020 by the Executive Director.	
RATING	☐	☒	☐	☐	☐	The agency has a transportation policy that requires staff to make arrangements to transport youth and ensure the staff member is never in a one to one situation with any youth. When another youth care staff is unavailable to assist with transportation the youth care staff may utilize interns, volunteer or may utilize other youth during transport. The agency does have in place a procedure if a 3rd party cannot be obtained for transport. During extreme cases the staff member	**Exception** Out of the six (6) one on one transport with youth and staff, there were four (4) that were not logged in logbook stating approval was given by supervisor but was logged on the vehicle mileage log. However, on the vehicle transport log, there is no evidence approval was given prior to transport as it does not state the name of the supervisor or time it was approved. The agency's policy also states that staff has to

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						may, with the permission of the Shelter Manager, transport youth one on one; however, once in the van the staff member must call the shelter via cell phone and place the phone on speaker for the shelter to witness the discussions in the van. The procedure also considers the client's previous behavior, the gender of the client, and other factors are taken into account including the background of the staff member. This approval must be documented in the van log by the van driver. The agency maintains a list of authorized drivers for 2020 and copy was provided for review. The list consists of twenty-three (23) drivers/employees. The agency has a vehicle mileage log, vehicle acceptance and return log, and staff utilize the e-log book to document transportation with the agency vehicles. The agency has three vehicles they utilize for transportation: Ford Big Silver, Toyota Silver van, and Ford white minivan. During review, the vehicle mileage log forms were observed and staff are documenting all van trips with dates, number of staff in vehicle, drivers name, number of youth with staff in vehicle, youth name that are in the vehicle, odometer miles beginning and end, destination, and time in and time out.	document all approvals on the vehicle transport log.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						In a review of the logbook, these dates were looked at on 1/22/2020, 10/14/2019,11/6/2019,8/23/2019, 2/4/2020, and 1/25/2020 -where staff had to get supervisor's approval for one on one transports.	
1.07: Outreach Services **The agency participates in local DJJ board and council meetings to increase public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services and ensure CINS/FINS services are represented in a coordinated approach.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						☒ YES ☐ NO (explain) The agency has a policy that addresses all elements of indicator 1.07 for Outreach Services. The policy was last reviewed and approved 1/28/2020 and signed by the Executive Director.	
RATING	☒	☐	☐	☐	☐	The program provides presentations in the community and distributes written information about their services. These written documents include annual reports, brochures, and posters. The agency also keeps a binder with outreach activities completed by the administrative or counseling staff. Documentation shows 21 events were attended and entered in Netmis between 8/2019-12/2019. 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,	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						truancy, safe place sites, employment services, educational, medical services, and support services. There was evidence of participation and attendance by a management staff for only one meeting dated 1/9/2019 to the Circuit 17 DJJ Advisory Board meetings. Current management emailed DJJ in July 2019 informing them of the program's new management for attendance to the DJJ meetings but has not received a reply.	

STANDARD 2: INTERVENTION AND CASE MANAGEMENT

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard Two – Intervention and Case Management							
2.01: Screening and Intake							
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						☒ YES NO (explain) The agency has a policy 2.01 for Screening and Intake that meets the requirement of the indicator. The policy was last reviewed 9/18/15 and approved by the Executive Director on 1/28/2020.	
RATING	☒	☐	☐	☐	☐	A total of five residential case files were reviewed (2 open, 3 closed) and five (5) non-residential files (2 open, 3 closed). All ten case files contained screenings that had been conducted within seven (7) calendar days of referral. All ten 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 exception
2.02: Needs Assessment							

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						☒ YES ☐ NO (explain) The agency has a policy 2.02 for Needs Assessment that meets the requirement of the indicator. The policy was last reviewed 9/18/15 and approved by the Executive Director on 1/28/2020.	
RATING	☒	☐	☐	☐	☐	A total of five residential files were reviewed (2 open, 3 closed) and five non-residential files (2 open, 3 closed). All 5 residential case files reviewed had a Needs Assessment initiated within 72 hours of admission. All five 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 exception
2.03 Case/Service Plan							
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						☒ YES ☐ NO (explain) The agency has a policy 2.03 for Case/Service Plans that meets the requirement of the indicator. The policy was last reviewed 9/18/15 and approved by the Executive Director on 1/28/2020.	
RATING	☒	☐	☐	☐	☐	A total of 5 residential case files were reviewed (2 open, 3 closed) and five non-residential files (2 open, 3 closed). Each file contained a tailored case/service plan based	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						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. However, two out of the three closed non-residential files were missing service plan completion dates and one non-residential file was missing service plan person responsible. However, progress notes did confirm that services were provided, and goals were met upon discharge.	
2.04: Case Management and Service Delivery							
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						☒ YES ☐ NO (explain) The agency has a policy 2.04 for Case Management and Service Delivery that meets the requirement of the indicator. The policy was last reviewed 9/18/15 and approved by the Executive Director on 1/28/2020.	
RATING	☒	☐	☐	☐	☐	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.	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						A total of five residential files were reviewed (2 open, 3 closed) and five non-residential files (2 open, 3 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 has establishing referral needs, coordination referral to services, monitoring the youth's and family's progress and providing support to the family when needed. All ten cases progress of services were monitored and all ten were provided family support. The five residential cases were monitored for out of home placement. The five non-residential cases did not require out of home monitoring as it was not necessary. All ten cases reviewed did not require case staffing.	
2.05: Counseling Services							
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						☒ YES ☐ NO (explain) The agency has a policy 2.05 for Counseling Services that meets the requirement of the indicator. The policy was last reviewed 9/18/15 and approved by the Executive Director on 1/28/2020.	
RATING	☐	☒	☐	☐	☐	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 to include a clear leader or facilitator, relevant topic (educational, informational or developmental), opportunity	**Exception** One closed residential file was missing case notes even though the file was open approximately 2 months and despite the service plan being signed.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						for youth to participate, and be 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 five residential case files were reviewed (2 open, 3 closed) and five non-residential files (2 open, 3 closed). All files indicate that counseling services were made available to all clients, either through referral services or in-house treatment. However, one closed residential file was missing case notes even though the file was open approximately 2 months despite the Service Plan being signed. In the residential setting, group counseling is being offered at a minimum of 5 days per week. Group counseling is offered for residential clients at different times to ensure that all clients are served. The five 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 including interns.	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
2.06: Adjudication/Petition Process							
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						☒ YES ☐ NO (explain) The agency has a policy 2.06 for Adjudication/Petition Process that meets the requirement of the indicator. The policy was last reviewed 9/18/15 and approved by the Executive Director on 1/28/2020.	
RATING	☒	☐	☐	☐	☐	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. Two applicable non-residential files were reviewed for this indicator. The case files 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	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						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, mental health representative, and a substance abuse representative. As a result of the case staffing, new case/service plans were implemented and signed by both the client and the parent. A review summary was completed by the assigned counselors prior to the court hearings.	
2.07: Youth Records							
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						☒ YES ☐ NO (explain) The agency has a policy 2.07 for Youth Records that meet the requirement of the indicator. The policy was last reviewed 9/18/15 and approved by the Executive Director on 1/28/2020.	
RATING	☒	☐	☐	☐	☐	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	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						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 ten 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.	
2.08: Sexual Orientation, Gender Identity, Gender Expression							
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						☒ YES ☐ NO (explain) 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 Director1/28/2020.	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
RATING	☒	☐	☐	☐	☐	During a tour of the facility, various types of signage including a painting, Trevor Project posters, rainbow flags, and rainbow stickers were observed throughout the facility in the lobby, counseling hallway, offices, group room, and the youth lounge of the shelter. Combined, the signage communicates the message that all youth are welcome and should feel safe regardless of sexual orientation, gender identity, and gender expression. The program also has published materials to provide education and information about LGBTQ: one from SunServe entitled “Helping People Connect” and a postcard connecting youth to resources. The program also has the FN Zine, “I Provide Safety Support and Respect” to provide to youth/parent as needed. Youth identified as needing support services are referred to SunServe, a local nonprofit organization that offers multiple resources for LGBTQI youth as wells 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.	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						The training file for 4 new staff reviewed supported all 4 staff received training on gender orientation of youth and are made aware of the Florida Network's policy 5.08 SOGIE policy during orientation. Sign in sheets dated 6/12/2018, 6/14/2019, and 9/19/2019 were provided demonstrating in-service staff had reviewed the SOGIE policy guidelines outlined in FN policy #5.08. All 3 youth surveyed stated they feel the shelter is a safe place regardless of sexual orientation and/or gender identity. None of the 3 youth reported any adults in the program attempting to change their minds about their sexual orientation, gender identity, or gender expression. Interns are required to receive training specific to providing cross cultural counseling as part of their core training requirement that must be completed prior to engaging in an internship.	
2.09: Special Populations							
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						☒ YES ☐ NO (explain) The agency has a written policy and procedure that meets all required elements listed in the Florida Network standards for indicator 2.09. The policies were last approved on 1/28/2020 by the Executive Director.	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
RATING	☒	☐	☐	☐	☐	During the entrance meeting, the Executive Director stated that LSF SE does not currently serve Probation Respite, ICM, or FRYRAC youth. During the review period, the agency had served 5 domestic violence youth. A review of three of the five Domestic Violence Respite files was conducted. Delinquency face sheets were provided in all 3 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. One of the three youth exceeded the length of stay of 21 days for placement. Documentation was present in the file showing the DV case was closed out in NetMIS on the 21st day and transitioned to CINS/FINS thereafter. Case/treatment plans 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 exception
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						☐ YES ☐ NO (explain) ☒ **N/A**	

Lutheran Services Florida Southeast – February 5-6, 2020
Lead Reviewer: Marcia Tavares

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
RATING	☐	☐	☐	☐	☒	Lutheran Services Florida Southeast is not contracted to provide SNAP services	

STANDARD 3: SHELTER CARE

Quality Improvement Indicators	Rating: Satisfactory	Rating: Explain: Deficiency Identified	Rating: Explain: No Eligible Items For Review	Rating: Explain: No Practice	Rating: Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
Standard Three – Shelter Care							
3.01 Shelter Environment **The shelter's environment is safe, clean, neat and well maintained. The program provides structured daily programming to engage youth in activities that foster health, social, emotional, intellectual and physical development.**							
Provider has a written policy and procedure that meets the requirement Sheets for the chemicals utilized in the program. Or Indicator 3.01						☒ YES ☐ NO (explain) The agency has a written policy and procedure that meets all required elements listed for indicator 3.01. The policies were last approved on 1/28/2020 by the Executive Director.	
RATING	☐	☒	☐	☐	☐	During the walk through of the shelter it was observed that the shelter was recently paint with bright colors and chalk board painted doors. Furnishings were in good repair the building was free of insect infestation. Bathrooms, bedrooms and common areas were free of any contraband and hazardous objects. The grounds were well maintained and hazard free. Bathrooms and shower rooms were clean and functional and the lighting in the shelter was adequate to perform tasks. All exterior areas are free of debris and dumpsters were covers. All agency and staff vehicles were locked. Agency vehicles were equipped with safety equipment which included first aid kits, fire extinguisher, flashlight, glass breaker, seat belt cutter and air bag deflator. All staff appeared to be compliant with key control.	**Exception:** Program did not have MSDS sheets on the chemicals utilized in the program. While on site an MSDS binder was completed with safety data sheet on all shelter chemicals.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						The shelter had posted information for staff and youth that consisted of egress plans, shelter rules, grievance procedures, abuse hotline information and DJJ reporting procedures. The agency has a current DCF license displayed in the shelter. DCF license was effective 6/28/2019. Chemicals are approved, and inventoried weekly. When on site all chemicals were locked in storage bins on the outside of the shelter. The shelter has two washers and dryers and bother were operable when on site. Each youth has own bed with a clean mattress covers, pillow and blanket. A laundry schedule for lines was posted in the shelter. All youth have a safe lockable area for personal belongings. Annual fire inspection was completed on 8/07/2019 with no violations. An annual review of the extinguishers, sprinklers, and alarm systems were conducted on 8/7/2019. All fire equipment was tagged and up to date. Reviewed fire drill logs and all drills were conducted with in one to two minutes as required	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						and completed monthly. Reviewed mock emergency drill log sheets meets the standers. The program has a satisfactory health inspection completed on 12/30/2019. The health inspection had three violations #47-Food nonfood contact surface, #15 food separated to protect, and #23 date marked for disposal. The shelter fixed #15 and #23 when the health inspector was on site. Violation #47 has not been fix however the shelter is in the process of getting estimates to fix the countertop surface area. All menus were posted and signed by dietitian. All food items appeared to be properly stored and labeled. Freezers and refrigerators are clean and functional. Freezer temperature –2 degrees and refrigerator temperature 36 degrees. 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. 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. Daily programming includes opportunities for youth to	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						complete homework and access books in the facility library that have been approved by the agency. Daily programming schedule is publicly posted in the two areas (living room and provided to the youth) and accessible to both staff and youth.	
3.02: Program Orientation							
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						☒ YES ☐ NO (explain) The agency has a written policy and procedure that meets all required elements for indicator 3.02. The policies were last approved on 1/28/2020 by the Executive Director.	
RATING	☒	☐	☐	☐	☐	Youth admitted to the shelter go through a comprehensive client orientation process consisting of 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 four residential program orientation files (two open and two closed) indicated that all four clients received a comprehensive orientation during the intake process which is documented on the Client Orientation Check List initialed by staff and youth. All four 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, suicide prevention, daily activity schedule and abuse hotline numbers supplied.	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
3.03: Youth Room Assignment							
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						☒ YES ☐ NO (explain) The agency has a written policy and procedure that meets all required elements for indicator 3.03. The policies were last approved on 1/28/2020 by the Executive Director.	
RATING	☐	☒	☐	☐	☐	Four residential files were reviewed (two closed and two open files) and all files had clients receiving a general classification and room assignment while being admitted into 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 the client. The classification also included, client history on youth disabilities, suicide risk, gender identification, 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.	**Exception** The portion of the CINS/FINS Intake Assessment form under the room assignment section was only partially completed in all four files reviewed. The reviewer could not determine if staff completed a risk assessment and screened the youth for a history of violence, gang affiliation, sexually aggressive or reactive behaviors.
3.04: Log Books							
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						☒ YES ☐ NO (explain) The agency has a written policy and procedure that meets all required elements for indicator 3.04. The policies were last approved on 1/28/2020 by the Executive Director.	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
RATING	☒	☐	☐	☐	☐	The Electronic logbook includes entries that could impact the security and safety of the youth and/or program which are highlighted. All entries 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. Errors are corrected by striking a line through all errors in recording in the logbook. The program supervisor reviewed the logbook every week and made notes indicating the dates reviewed and if any correction were needed. All oncoming supervisors and direct care staff review the logbook from the previous two shifts. The logbook has documentation that show visitation and home visits.	No exception
3.05: Behavior Management Strategies							
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						☒ YES ☐ NO (explain) The agency has a written policy and procedure that meets all required elements for indicator 3.05. The policies were last approved on 1/28/2020 by the Executive Director.	
RATING	☒	☐	☐	☐	☐	The agency has a detailed written description of the behavioral management system (BMS) that is intended to gain compliance with program rules but to impact the youth to make positive choices.	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						The program has a wide variety of rewards (recreational outings, extra privileges), appropriate consequences, and behavioral management system which is based on a token economy of points and phrases is used to teach youth new behaviors and help youth to understand the naturel consequences for their own actions. The 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 four files, it was confirmed that staff does explain the (BMS) during program orientation and acknowledgement of resident handbook. In addition, staff document the behavioral notes daily. The shelter Manager reviews youth behavioral sheets and provides feedback to staff on the usage of positive and negative consequences. Training files were reviewed, and it was observed that staff had training on the BMS rewards and consequences. Upon admission to the shelter, each youth receives a coping skills form where she/he writes their coping skills to use when they are angry to help manage their behavior. Also, a youth is given	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						a Daily Skill Card that is used to document points and 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 immediate consequences receiving loss of privileges or phase levels. The goal is to receive checks/points per day for good behavior on their card in order to be allowed to visit the prize cabinet.	
3.06: Staffing and Youth Supervision							
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						☒ YES X ☐ NO (explain) The agency has a written policy and procedure that meets all required elements for indicator 3.06. The policies were last approved on 1/28/2020 by the Executive Director.	
RATING	☒	☐	☐	☐	☐	The Shelter ensures staffing ratios are maintained as follows: 1 staff to 6 youth during awake hours and community activities. Overnight shifts always have a minimum of 2 staff on duty verified by shelter schedules. The shifts are 8 hours with variations of 7am-3pm, 3pm-11pm, and 11pm-7am. There is ample coverage, two staff on duty per shift. After reviewing a sample size of the past four months of schedules, a lot of substitutions in coverage was made, but always stayed within ratio. The schedule is posted in the office area for staff to review and an overtime roster of staff that	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						include telephone numbers is available for additional coverage when needed. There is a policy for beds checks that meets the standards every 15-minute intervals during sleep hours. A review of the program logbook on random overnight bed checks was conducted for the following dates: 11/15/2019, 12/12/2019, 12/22/2019 and 1/31/2020. All 15-minute bed checks were conducted in real time in the electronic logbook.	
3.07: Video Surveillance System							
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						☒ YES ☐ NO (explain) 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 last approved on 1/28/2020 by the Executive Director.	
RATING	☒	☐	☐	☐	☐	The shelter has a video surveillance system that has not been able to record since 12/20/2019. An incident report was completed and the CCC was notified. Tech support was contacted on 12/20/2019. Tech support came to the shelter on 12/26/2019 but was unable to fix the hard drive. The Shelter Manager purchased a new hard drive for the system on 1/092020 and is waiting for the IT department to install the new hard drive for the surveillance system.	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Reviewer was unable to verify if the system can capture and retain a minimum of 30 days of video, record date and time, location and maintain resolution that enables facial recognition. All other indicators in this standard were reviewed. Cameras cover all general areas, but not sleeping rooms or rest rooms. Only accessible to designated personnel, a list is maintained of personnel. Bi-weekly supervisory reviews are noted in the logbook and a camera review log is maintained. All cameras are visible and a written noticed that the cameras are in use is posted in the shelter.	

STANDARD 4: MENTAL HEALTH/HEALTH SERVICES

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
Standard Four – Mental Health /Health Services							
4.01: Healthcare Admission Screening							
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						☒ **YES** ☐ **NO (explain)** Policy 4.01 - Healthcare Admission Screening. The policy was authorized by the Executive Director on 01/28/20.	
RATING	☒	☐	☐	☐	☐	A review of three closed records and one open record was conducted for the purpose of healthcare admission screening. Reviewed documentation reflected screening forms were completed, as required, in each record reviewed. Health care screenings included current medications, existing medical conditions (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 reviewed records indicated the youth had a chronic medical condition needing an immediate referral.	No exception
4.02 Suicide Prevention **There is a written plan that details the program's suicide prevention and response procedures. The plan complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.**							

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						☒ **YES** ☐ **NO (explain)** Policy 4.02 - Suicide Prevention. The policy was authorized by the Executive Director on 01/28/20. Date of last review: 10/01/18. Date of last revision: 09/17/15.	
RATING	☒	☐	☐	☐	☐	A review of three closed records and one open record was conducted for the purpose of suicide prevention. Reviewed documentation reflected Suicide Risk Screening and Precautionary Observation Log forms were completed in each of the records reviewed, as required. Reviewed practice coupled with an informal interview with the Clinical Director confirmed the program follows all contracted obligations for the screening and response to youth at risk of suicide. All suicide screenings and assessments were conducted according to the required time frames utilizing the approved tools. The screening results were reviewed and signed by the licensed mental health professional and was documented in the youth's case record for each reviewed youth. Each youth was placed on sight and sound supervision until assessed and removed by the licensed professional. When placed on one-to-one supervision or constant supervision, observation logs confirmed the program's practice is to monitor youth behavior at ten-minute	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						intervals. Each youth's supervision level was not changed or reduced until a licensed professional completed a further assessment. Three staff were surveyed regarding the location of the program's Suicide Response Kit and what they would do if a youth expressed suicidal thoughts. One of the surveyed staff reported the Suicide Response Kit is wall-mounted within the program while the other two staff reported it is located on the wall in the common area as well as the staff station desk or cabinet. Each of the three staff reported if a youth expressed suicidal thoughts, direct care staff are responsible for constant sight and sound supervision, documentation of supervision, and searching the youth and the room for hazards. Two of the three staff reported they would also notify a mental health authority as well.	
4.03: Medication							
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						☒ **YES** ☐ **NO (explain)** Policy 4.03 - Medications. The policy was authorized by the Executive Director on 01/28/20. Date of last review: 10/01/18. Date of last revision: 08/30/18.	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
RATING	☐	☒	☐	☐	☐	Observations made of the medical office reflected the program has a Pyxis Med-Station 4000 Medication Cabinet located in the medication room which is inaccessible to youth (when unaccompanied by authorized staff). The program has a list of fourteen staff members and a two part-time registered nurses (RNs) who have been trained and authorized to assist in the distribution of medication to the youth. The two staff members and the two part-time nurses are assigned as Super Users for the Med-Station. Reviewed documentation confirmed the program had one narcotic/controlled medication on-site for a non-CINS/FINS youth at the time of the annual compliance review. The medication was observed to be stored in the Med-Station in the medication room behind two locks and was documented on the youth's medication distribution log. An informal interview with the RN confirmed the program does not accept youth who are prescribed injectable medications (except epi-pens). Observations of the medication room also reflected the program has a small and secure refrigerator used to store any medications requiring refrigeration. At the	**Exception** There was no documentation maintained by the program to confirm the practice of monthly reviews of medication management practices being conducted by way of the Knowledge Portal or Pyxis Med-Station Reports.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						time of the review, there were no applicable medications housed in the refrigerator and the refrigerator was empty. According to the RN, there are no sharps or syringes used at the program at the time of the review. Oral medications are not stored with injectable or topical medications. Reviewed documentation coupled with an informal interview with the RN confirmed shift-to-shift counts are conducted and documented by staff and a witness for controlled substances. A perpetual inventory with running balances is maintained for controlled substances as well. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances, as confirmed by the RN. Over-the-counter medications which are accessed regularly are inventoried weekly through a perpetual inventory. When a youth is admitted to the program with a prescribed medication, the RN verifies the medication by contacting the pharmacy/doctor's office who prescribed it. Anytime there is a medication discrepancy, the Pyxis Med-Station 4000's software will detect a discrepancy in the count and a warning will appear on the login screen before the next user (shift)	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						can log in. Before they can log into the system, the discrepancy must be addressed by staff. The staff member attempting to clear the discrepancy must get another staff (witness) to conduct a recount. The staff will then enter the recounted amount and resolution information, such as the date and name of the person clearing the discrepancy as well as the reason why there was a miscount. All discrepancies are cleared each shift. Three staff were surveyed regarding if they assist youth in the delivery of medications and how are they informed of medication side effects. Two of the three staff reported they assist youth in the delivery of medication while one reported they do not. Each of the three surveyed staff reported they are informed of medication side effects by way of medical alert logs. Two of the three staff reported they are also informed through shift transitions and an alert form in the file. One staff also said the medication side effects are listed on the medication bottle and they can also call the pharmacy as well. Three youth were surveyed regarding if they have ever received medical care at the shelter and if so, how would they rate	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						the care? One of the three youth reported they have received medical care at the shelter and rated the care provided as decent. One of the three surveyed youth was female. This youth confirmed she receives female hygiene/sanitary products when needed.	
4.04: Medical/Mental Health Alert Process							
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						☒ **YES** ☐ **NO (explain)** Policy 4.04 - Medical/Mental Health Alert Processes. The policy was authorized by the Executive Director on 01/28/20.	
RATING	☒	☐	☐	☐	☐	The program has policy and procedures regarding a medical and mental health alert process which was approved, reviewed, signed, and dated by the Executive Director, Clinical Director, and Shelter Manager on 01/28/20. When a youth is admitted to the program, a shelter staff and/or assigned counselor completes the initial intake with each youth to determine and document the status of the youth's medical condition, if there are any mental health or substance abuse issues, and if there are any needs requiring immediate attention. The program maintains a color-coded alert board, which includes any applicable medical conditions, physical activity restrictions, allergies, common side effects of prescribed medications, food and	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						medication contraindication, and other pertinent treatment information of youth, located in the intake office. The program also maintains a food allergy alert list located in the program's kitchen. The alert board and allergy list are both inaccessible to youth. A review of three closed youth records and one open youth record reflected each youth was screened and appropriately placed on the program's alert system, as required. A review of the program's alerts included a review of applicable precautions concerning medications, medical conditions, and/or mental health conditions. A review of the program's food allergy alert list reflected the allergy list was up-to-date and there were no applicable youth on a special diet/nutritional needs at the time of the annual compliance review. Three staff were surveyed regarding how they are informed of a youth's medical alerts/mental health alerts as well as how effective do they believe the process is for communicating information at the program. Each of the three staff reported they are informed of medical/mental health alerts through shift transition and the medical alert log. Two of the three staff also reported receiving alerts through	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						staff meetings, census board, and the alert form in the file. Each of the three surveyed staff reported they feel the process for communicating information at the program is very good.	
4.05: Episodic/Emergency Care							
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						☒ **YES** ☐ **NO (explain)** Policy 4.05 - Episodic/Emergency Care. The policy was authorized by the Executive Director on 01/28/20.	
RATING	☐	☒	☐	☐	☐	The program has policy and procedures regarding Episodic/Emergency Care which was approved, reviewed, signed, and dated by the Executive Director, Clinical Director, and Shelter Manager on 01/28/20. Observations confirmed the program maintains two first aid kids within the shelter building, one located in the common area and the other located within the dining area. Furthermore, the program maintains first-aid kits within each of their three transportation vans. The program does not maintain an episodic/emergency care log. A review of the past six months of reports called into the Department's Central Communications Center (CCC) found there was one incident of	**Exception** There was no documentation in the one applicable youth's record to confirm a verification of receipt of medical clearance, discharge instructions, and follow-up care was received once the youth returned to the program. The program does not maintain a daily log of episodic/emergency care.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						episodic/emergency care. Reviewed documentation confirmed an incident report was submitted for a medical incident reflecting a youth who had an anxiety attack on the school bus during a transport on the way to school where emergency medical services (EMS) was contacted. According to the report, program staff pulled the van over in a school zone and a nearby law enforcement officer assisted and contacted EMS. EMS met with program staff, law enforcement, and the youth where the youth was diagnosed with an anxiety attack. The youth's parents were contacted and then picked the youth up on-site where the incident occurred. The youth's mother transported the youth back to the program the following day on 09/11/19. An informal interview with the program's Clinical Director confirmed all staff were trained on emergency medical procedures.	