FLORIDA NETWORK
of youth and family services

Florida Network for Youth and Family Services
Compliance Monitoring Report for

LSF SW - Oasis
3615 Central Avenue, Suite 3
Fort Myers, FL 33901

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for the LSF SW - Oasis for the FY 2019-2020 at its program office located at 3615 Central Avenue, Suite 3, Fort Myers, 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 SW - Oasis 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 Ashley Davies, Consultant for Forefront LLC and Peer Reviewer(s). Agency representatives from LSF SW - Oasis present for the entrance interview were: Shareet Pennino, Executive Director; Shelia Dixon, Clinical Director; Samuel Laguerre, Residential Program Manager. The last onsite QI visit was conducted December 5-6, 2018.

In general, the Reviewer found that LSF SW - Oasis is in compliance with specific contract requirements. **LSF SW - Oasis received an overall compliance rating of 100% for achieving full compliance with eleven indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit; however, no recommendation was made for an indicator rated as conditionally acceptable.

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 9-25-2019

Agency Name: LSF SW - Oasis	**Monitor Name: Ashley Davies, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 3615 Central Avenue, Suite 3, Fort Myers**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): September 25-26, 2019**

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.	☐	☐	☒	☐	☐	Interview: The program currently has two staff members certified as DJJ QI Peer reviewers. This was the first review of the season so neither staff member has participated as peer reviewer this season but are scheduled to participate on reviews later in the season.	**No recommendation or Corrective Action.**
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 additional contracts for FY 2019- 2020 was provided by the provider. The list includes name local, state and other funding sources. The agency provided a brief description of each program, description of services, amount funded and, and the funding agency. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, substance abuse, mental health partners, and other treatment providers. All of the agreements	**No recommendation or Corrective Action.**

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						reviewed had recent contract/agreement dates.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation 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**	☐	☐	☒	☐	☐	Documentation: The provider's General Liability; Workers Compensation; and Automobile insurance policies all meet the required minimums per the Limits of Coverage and are in effect for the current FY 2019-2020. The insurance includes: General Liability through Markel Global Reinsurance Company with effective dates 06/01/2019-06/01/2020. Automobile Liability through Markel Global Reinsurance Company with effective dates 06/01/2019-06/01/2020. Workers Compensation and Employers' Liability through Markel Global Reinsurance Company with effective dates 06/01/2019-06/01/2020.	**No recommendation or Corrective Action.**

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						The certificate does list the Florida Network on the consolidate certificate of liability as a 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**	☐	☐	☐	☐	☒	**N/A –** During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	**No recommendation or Corrective Action.**
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 7/2017 by the CEO and are updated as necessary with revised policies showing a revision/approval date.	**No recommendation or Corrective Action.**
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: Detail Trial Balance for July 1, 2019–August 31, 2019. 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 CINS/FINS (711) program and department codes 0801, 0803, 0804, and 0820.	**No recommendation or Corrective Action.**

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
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**	☐	☐	☒	☐	☐	Documentation and Observation: Petty cash policies and procedures are the same as reviewed during the last onsite visit. The agency maintains a balance of $1000 in petty cash. The cash is secured in a Safe and maintained by a designated Custodian. Cash is not used for anything purchased over $50. Purchase order to request petty cash is disbursed by the Residential Manager. Staff signs the request and receipt of the petty cash and also signs when the receipt is returned. Three staff: Residential Manager, Petty Cash Custodian, and a third witness sign the reconciliation, which is completed bimonthly.	**No recommendation or Corrective Action.**
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 one account Bank of America operating for the period March 2019- August 2019. Successful bank reconciliations were conducted within 6 weeks of receipt of bank statements, comparing ledger balances with balances reflected on the bank statements.	**No recommendation or Corrective Action.**
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.	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	**No recommendation or Corrective Action.**

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**							
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. It is responsible for submitting information for W2s, Quarterly 941 reports, and payroll taxes. Form 941 deposits and filings for the 1st and 2nd quarters of were received from the provider and reviewed. The provider is making deposits and payments as required.	**No recommendation or Corrective Action.**
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided a Budget Report including the current fiscal year to date information. The report tracks all budget categories by annual budget and remaining balance separately. Variances if applicable are identified through the beginning of the FY 2019-2020 to present for the CINS/FINS program. The program budget is reviewed and approved by the agency's Pres/CEO, Board, and Regional Director.	**No recommendation or Corrective Action.**
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	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2018 and 2017 was	**No recommendation or Corrective Action.**

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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**						completed. Financial audit was conducted for the past year and a copy was submitted directly to the Florida Network of Youth and Family Services for before November 2019.	
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. Also reviewed were Policy and Procedures for Case Records (9.5.01), Confidentiality of Client Information (G11.4), and Risk Management. Data is backed up daily on the agency's server. Electronic collection and transfer of sensitive data is governed by secure protocols, including the use of passwords and firewalls. All computers have up-to-date anti-virus protection.	**No recommendation or Corrective Action.**

CONCLUSION

LSF SW - Oasis has met the requirements for the CINS/FINS contract as a result of full compliance with eleven applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the thirteen indicators were not applicable because: 1) the provider does not have any outstanding corrective action item(s) cited by an external funding source, and 2) does not have any current inventory purchased with DJJ/FN Funds. Consequently, t**he overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited and no recommendation is 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, the majority of indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

SUMMARY OF RECOMMENDATIONS

Recommendation
There were no recommendations as a result of this review.

If required, the provider must submit a corrective action plan to address corrective actions 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.

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Lutheran Services Florida/SW-Oasis
Residential Program

September 25 – 26, 2019

Compliance Monitoring Services Provided by

FOREFRONT

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

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

Standard 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)	Satisfactory

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

Standard 3: Shelter Care & 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: 100.00%
Percent of indicators rated Limited: 0.00%
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

Ashley Davies, Consultant-Forefront LLC, Florida Network of Youth and Family Services

Marie Lockwood, Regional Monitor, Department of Juvenile Justice

William Thomas, Assistant Director, Bethel Community Foundation, Inc.

Shad Renick, Program Director, Sarasota Y Youth Shelter

Kelly Barnett, Program Supervisor, Children's Home Society

Quality Improvement Review

LSF/SW-Oasis – September 25-26, 2019
Lead Reviewer: Ashley Davies

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
- **NA** # Food Service Personnel
- **1** # Healthcare Staff
- **NA** # Maintenance Personnel
- **NA** # 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
- **5** # Health Records
- **3** # MH/SA Records
- 15 # Personnel /Volunteer Records
- **8** # Training Records
- **5** # Youth Records (Closed)
- 5 # Youth Records (Open)
- **NA** # Other: _____

Surveys

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

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

Lutheran Services Florida (LSF) SW Oasis CINS/FINS program was awarded a Community Development Block Grant (CDBG). On October 24, 2018, LSF SW Oasis was notified that the submitted CDBG proposal was approved as follows: Oasis youth shelter improvements for $43,250, for an outside backyard screened in building and a renovated basketball court, and CINS/FINS nonresidential counseling program building Improvements for $36,750.00 which included new flooring and a new roof. The total award was initially $80,000. However, that has been increased due to an increased amount of supplies and labor for the screened in building. All the improvements and renovations are complete currently with the exception of the outdoor building. This should be completed by the end of September.

Under the leadership of Shelia Dixon, LCSW, the Stop Now and Plan (SNAP) program in Circuit 20, a five-county area, has been fully implemented. Contract goals for last FY were met. The program is staffed with two full time employees. LSF SW Oasis has made the SNAP facilitator part-time positions available to their youth care specialist (YCS) and counseling staff at an enhanced rate of pay. This also provides YCS staff growth in their professional development. The SNAP in schools has been ongoing in Charlotte county. All CINS/FINS performance measures were met for last fiscal year.

Of the currently employed CINS/FINS counselors there is one registered mental health counselor and two registered clinical social work interns under the supervision and direction of Ms. Dixon. In addition, there are three staff who have completed the application process to become registered clinical social work interns.

The shelter supervisor attended and successfully completed the *Residential Child and Youth Care Professional* training through National Resource Center for Youth Services, University of Oklahoma outreach, in July 2019. The supervisor is currently scheduling the test to certify others.

Mr. Raymond Ballinger, Shelter Manager, was promoted to Executive Director of SE programs in June 2019. Samuel Laguerre was promoted to shelter manager. Sam has been with LSF since 2014. He started as an intern working on his bachelor's degree, he became a YCS and then became a YCS Lead. After earning his bachelor's degree from Florida Gulf Coast University, he became the shelters substance abuse prevention and outreach counselor. Sam is also certified to teach Managing Aggressive Behavior.

Midyear, Keller Williams real estate chose LSF SW Oasis youth shelter as their day of caring. There were more than 100 Keller Williams employees at the shelter putting new floors in all the bedrooms, painting all the walls, putting artwork on the walls, landscaping, and purchased brand new bedding for all rooms.

In August of this year LSF purchased twelve brand new beds and twenty-four new mattresses for the bedrooms at the shelter.

Under the leadership of Shelia Dixon, LSF SW region Intensive Case Management Services was awarded “Program of the Year” by the Florida Network of Youth and Family Services. In addition, a previous shelter youth was awarded Youth Resiliency of the Year.

Standard 1: Management Accountability

Overview

Lutheran Services Florida SW Oasis Youth Shelter is managed by an executive director who oversees a shelter manager and a clinical director. At the time of the review there were four vacant youth care specialist (YCS) I positions and nine vacant YCS I temp positions. In June 2019, the previous shelter manager was promoted to executive director of southeast programs. A counselor who has been with the agency for five years was promoted to shelter manager.

The program collects and reviews data from various sources on a monthly basis. Data is reviewed with all staff during monthly team meetings and goals are developed for any priority issues. The clinical director reviews information in JJIS and NetMIS monthly to ensure accuracy of data entry and collection.

The following indicators were rated satisfactory with exceptions for indicators 1.01 Background Screening and 1.04 Training Requirements. The exceptions noted in 1.01 Background Screening were two five-year re-screenings not completed in the appropriate time frame. The exceptions noted in 1.04 Training Requirements were in training files reviewed for first year employees that revealed some required trainings completed outside the 120-day requirement. All other indicators were rated satisfactory with no deficiencies.

Standard 2: Intervention and Case Management

Overview

Lutheran Services Florida SW Oasis Youth Shelter provides residential and non-residential counseling and case management services over five counties, Collier, Hendry, Glades, Charlotte, and Lee, across Circuit 20.

The clinical director, who is a Licensed Clinical Social Worker (LCSW), oversees both programs. The residential counseling program consists of two counselors and a youth and community engineer coordinator. One of the counseling positions was vacant at the time of the review and the other counseling position was a master's level counselor.

The non-residential counseling program is housed on-site in a separate building on the same property as the youth shelter. The non-residential program consists of seven counselors and a case manager. Out of the seven counselors one is a Licensed Mental Health Counselor (LMHC), three are master's level counselors, and three are bachelor's level counselors. The case manager is also a bachelor's level case manager.

The non-residential program also offers Intensive Case Management (ICM) and Stop Now and Plan (SNAP) services. ICM services are provided by an ICM coordinator and a case manager. At the time of the review the case manager position was vacant. The ICM coordinator is a bachelor's level staff. SNAP services are provided case a site coordinator, a case manager, and two part-time facilitators. At the time of the review one of the part-time facilitator positions was vacant. All three staff current staff members providing SNAP services are bachelor's level staff. The clinical director oversees both ICM and SNAP services. The program has provided domestic violence, probation respite, and ICM services.

At the time of the review the program had not provided any staff secure, domestic minor sex trafficking, or Family and Youth Respite Aftercare (FYRAC) services. The agency is currently maintaining paper files.

All indicators in standard two were rated satisfactory with the only exception noted in indicator 2.10 Stop Now and Plan (SNAP). The exception in 2.10 was due to both sessions of SNAP in Schools reviewed not documenting a pre evaluation for the teacher and each youth. All other indicators in standard two were rated satisfactory with no deficiencies.

Standard 3: Shelter Care

Overview

Lutheran Services Florida SW Oasis Youth Shelter residential program is lead by a shelter manager and a youth care specialist (YCS) III. The shelter runs three shifts. Each shift is lead by a YCS II. The first shift has four YCS I and five vacant YCS I positions. The second shift also has four YCS I and five vacant YCS I positions. The third shift has three YCS I and three vacant YCS I positions.

The program was awarded a Community Development Block Grant (CDBG) and at the time of the review the shelter was currently building an outdoor, backyard, screened building and had renovated the basketball courts. The non-residential building received a new roof and new flooring from this grant.

Keller Williams real estate chose LSF SW Oasis Youth Shelter as their day of caring. There were more than 100 Keller Williams employees that volunteered at the shelter to

put in new floors in all the bedrooms, paint all the walls, put artwork on the walls, do landscaping, and purchase brand new bedding for all rooms. LSF purchased twelve brand new beds and twenty-four new mattresses for the bedrooms at the shelter.

The youth shelter has a boy's hallway and a girl's hallway. Each hallway has six rooms with two beds in each room for a total of twenty-four beds. There are nine beds licensed for CINS/FINS services. At the time of the review there were seven CINS/FINS youth in the shelter.

All indicators in standard three were rated satisfactory with exceptions noted in indicators 3.01 Shelter Environment, 3.04 Log Books, 3.06 Staffing and Youth Supervision, and 3.07 Video Surveillance System. Exceptions noted in 3.01 were due to mock drills not consistently being conducted on the third shift. Exceptions noted in 3.04 were due to the supervisors and YCS not consistently documenting a review of the previous two shifts in the log book. Exceptions in 3.06 were due to three different occasions where there was a gap of over twenty-five minutes in the bed checks. Exceptions in 3.07 were due to the cameras only having storage for approximately twenty-one days instead of the required thirty days. All other indicators in standard three were rated satisfactory with no deficiencies.

Standard 4: Mental Health/Health Services

Overview

The residential counseling services in the shelter are overseen by the clinical director who is a Licensed Clinical Social Worker (LCSW). Services are provided by two counselors and a youth and community engineer coordinator. One of the counseling positions was vacant at the time of the review and the other counseling position was a master's level counselor.

All youth are screened for suicide at intake using the six approved questions on the CINS Intake Assessment form. If youth receive a positive screening they are placed on sight and sound supervision until seen and assessed by a qualified mental health professional. All staff receive training on suicide prevention.

Health services are overseen by a part-time registered nurse (RN). The RN is on-site various hours and days each week but is always on-site at least twenty hours a week. The RN will distribute all medications when on-site and trained YCS will distribute medications when the RN is not on-site.

The RN provides training for all newly hired staff on the medication distribution process and the Pyxis Med-Station 4000 Medication Cabinet. Refresher training is provided for as needed.

All medications in the facility are stored in the Pyxis Med-Station 4000 Medication Cabinet. The RN completes a weekly inventory of all medications on-site. YCS complete shift-to-shift inventories of all controlled medications and maintain perpetual inventories of all other medications.

All indicators in standard four were rated satisfactory with the only exceptions noted in indicator 4.02 Suicide Prevention. The exception noted in 4.02 was due to a current youth on site and sound supervision was placed in a sleeping room were staff did not have continuous sight and sound supervision of the youth. All other indicators in standard four were rated satisfactory with no deficiencies.

STANDARD 1: MANAGEMENT ACCOUNTABILITY

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 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) A policy titled 1.01 Background Screening is in place and was reviewed on August 21, 2019 by the Executive Director.	No exceptions
RATING	☐	☒	☐	☐	☐	There were seven newly hired staff, four interns, and one volunteer who were reviewed for a background screening completed prior to hire. All twelve documented a background screening was completed prior to hire with an eligible rating. There were three newly hired staff applicable for a pre-employment suitability assessment and all three had one completed with a rating of seven or higher. All seven newly hired staff had documentation of E-Verify obtained from the Department of Homeland Security. The Affidavit of Annual Compliance was completed and submitted on January 3, 2019.	There were three staff eligible for a five-year re-screening. Only one staff documented the re-screening was completed in the applicable time frame. The other two were not completed in the appropriate time frame due to the program using the employee's fingerprint re-screen date, rather than the initial hire date, as the date to do the five-year re-screening.
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 (explain)	No exceptions

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 policy is in place titled 1.02 Provision of an Abuse Free Environment and was reviewed on September 21, 2019 by the Executive Director.	
RATING	☒	☐	☐	☐	☐	All staff have signed a code of conduct. There is signage throughout the facility reflecting all youth are accepted. There are posting of the Abuse Hotline number in the shelter. The program has a process in place for documenting abuse hotline calls. Management takes immediate action to address incidents of physical, psychological abuse, verbal intimidation, use of profanity, to excessive use of force. There is an accessible and responsive grievance process in place. There is a locked grievance box in the shelter. Direct care staff do not handle grievances. All grievances were resolved within seventy-two hours by management. Grievances are maintained for at least one year.	No exceptions
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						☒ YES ☐ NO (explain) There is a policy in place titled 1.03 Incident Reporting that was last reviewed August 21, 2019 by the Executive Director.	No exceptions
RATING	☒	☐	☐	☐	☐	The program notified the Department's CCC no later than two hours after reportable incidents. All follow-up communication tasks/special instructions were completed as required by the CCC.	No exceptions

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		
						Incidents are documented in program logs. Incidents are documented on incident reporting forms. All incident reports were reviewed and signed by the program supervisor.	
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) There is a policy in place titled 1.04 Training Requirements that was reviewed August 21, 2019 by the Executive Director.	No exceptions
RATING	☐	☒	☐	☐	☐	An individual training file was maintained for each staff that included an annual employee training hour tracking form and related documentation. There were three staff training files reviewed for training completed in the first year of employment. One staff did not complete three trainings required in the first 120 days; the other two staff did not complete four required trainings in the first 120 days. All these trainings were completed; however, were outside the 120-day requirement. All other trainings required after the first 120 were completed for all three staff. All three staff documented over the 80 required training hours for the first year of employment. There were five staff training files reviewed for annual training requirements. The 2019 training cycle was reviewed so all five staff still had three months left in	Training files reviewed for first year employees revealed some required trainings completed outside the 120-day requirement.

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 cycle to receive additional trainings. All five staff were on track to receive all required trainings and well over the required training hours.	
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) There is a policy in place titled 1.05 Analyzing and Reporting Information that was last reviewed August 21, 2019 by the Executive Director.	No exceptions
RATING	☒	☐	☐	☐	☐	The agency completes monthly reviews of case records. There are also monthly reviews of incidents, accidents, and grievances. Customer satisfaction data is reviewed monthly. Netmis data is reviewed monthly. Findings from these monthly reviews are discussed during the monthly team meetings and during the monthly clinical programs team meeting. A CQI Monthly Spreadsheet and Companion report is created with all the above information and presented in the monthly clinical programs team meeting. Goals are then developed for any priority issues. This information is then shared with all staff during the monthly team meetings. The clinical director reviews information in JJIS and NetMIS monthly to ensure accuracy of data entry and collection.	No exceptions
1.06: Client Transportation							

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		
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 in place titled 1.06 Client Transportation that was last reviewed August 21, 2019 by the Executive Director.	No exceptions
RATING	☒	☐	☐	☐	☐	The program has a policy to have a third-party present during single youth transport. The program has an approved driver's list that documents the date the driver was approved alongside the driver's valid driver's license number. Each driver is covered under the company insurance policy that was reviewed. In cases where there were single transports there is evidence that program management has approved the single transport. This documentation is found in the transportation log, as well as, in the Note Active Logbook. The program manager is generally the management member approving these transports. There were also several instances where there were two staff who provided transportation to a single youth. The transportation log includes the name of the driver, the number of staff, the date, the time in and out, the activity and location, the mileage in and out, as well as, a spot for cleanliness/maintenance comments.	No exceptions
1.07: Outreach Services							

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 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 in place titled 1.07 Outreach Services that was last reviewed August 21, 2019 by the Executive Director.	No exceptions
RATING	☒	☐	☐	☐	☐	A program representative attends the Juvenile Justice Advisory Board Meetings on a quarterly basis. There are agendas and meeting minutes for the meetings in January 2019 and April 2019. There is an agenda for the September 2019 meeting, but no minutes at this time. A representative also attends regular meetings with the Gulf Coast Partnership Stakeholders (4/19, 5/19, 7/19 with agendas provided) and Lee County Homeless Coalition (5/19, 6/19, 8/19 with agendas and minutes provided). The agency has created an LSF Advisory Committee that involves community stakeholders and they have met in March and September 2019. The program also has documentation of regular outreach/presentation events with community agencies and populations. The program has interagency agreements with a large number of community agencies with agreements signed.	No exceptions

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 in place titled 2.01 Screening and Intake that was last reviewed on August 22, 2019 by the Executive Director.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five non-residential files (two open and three closed) and five residential files (three open and two closed) reviewed. All files reviewed had the eligibility screening within seven calendar days of the referral. At intake the youth and parent/guardian received available service options, rights and responsibilities of the youth and parent/ guardian, and parent/guardian brochure. At intake both the parent/guardian and youth were also informed about the possible actions occurring through involvement with CINS/FINS and grievance procedures.	No exceptions
2.02: Needs Assessment							
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						☒ YES ☐ NO (explain) The agency has a policy in place titled 2.02 Needs Assessment that was last	No exceptions

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 on August 22, 2019 by the Executive Director.	
RATING	☒	☐	☐	☐	☐	There were five non-residential files (two open and three closed) and five residential files (three open and two closed) reviewed. Needs assessments were initiated and completed within forty-eight hours of the youth's admission to the program. Written assessments were completed by a bachelor's or master's level staff and include a supervisor signature. Of the ten files reviewed, none were identified with an elevated risk of suicide.	No exceptions
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 in place titled 2.03 Case/Service Plan that was last reviewed on August 22, 2019 by the Executive Director.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five non-residential files (two open and three closed) and five residential files (three open and two closed) reviewed. All had a case plan developed within seven days of the completion on the need's assessment. Each case plan included: individualized and prioritized needs and goals, service type, frequency and location, persons responsible, target dates for completion, actual completion dates, signature of the youth, signature of the parent, signature of	No exceptions

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 counselor and supervisor, and date the plan was initiated. Each plan was reviewed every thirty days, as applicable.	
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 in place titled 2.04 Case Management/Service Delivery that was last reviewed on August 22, 2019 by the Executive Director.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five non-residential files (two open and three closed) and five residential files (three open and two closed) reviewed. All files were assigned a counselor that was easy to identify within the files. There was clear evidence of referrals to services as needed, case plan coordination, monitoring of youth and family progress, and support for families. All thirty- and sixty-day follow-ups were completed, as applicable.	No exceptions
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 in place titled 2.05 Counseling Services that was last reviewed on August 22, 2019 by the Executive Director.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five non-residential files (two open and three closed) and five residential files (three open and two closed) reviewed. All files reflected case	No exceptions

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		
						coordination between presenting problem and the needs assessment, case plan, case plan reviews, and case management and follow-ups. Case notes were maintained for all counseling services and documented progress. There was an on-going internal process that ensures clinical reviews of files and staff performance. Youth and families received counselling services in accordance with the case plan. The program provided individual and family counseling. Group counseling was provided at least five days a week and consisted of a clear leader, relevant topic, opportunity for youth to participate, and were at least thirty minutes long.	
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 in place titled 2.06 Adjudication/Petition Process that was last reviewed on August 22, 2019 by the Executive Director.	No exceptions
RATING	☒	☐	☐	☐	☐	Three closed petition files were reviewed. All files followed proper procedures for notification. Case staffing's included all required parties. The youth and family were provided a revised plan for services. A written report was provided to the parent within seven days of the staffing. The program has an established case staffing committee and has regular communication with committee members.	No exceptions

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 an internal procedure for the case staffing process, including a schedule for committee meetings.	
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 in place titled 2.07 Screening and Intake that was last reviewed on August 22, 2019 by the Executive Director.	No exceptions
RATING	☒	☐	☐	☐	☐	All files were marked confidential. All files were kept in a secure room. Files were transported in a locked, opaque container marked confidential. All files were maintained in a neat and orderly manner.	No exceptions
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 agency has a policy in place titled 2.08 Sexual Orientation, Gender Identity, Gender Expression that was last reviewed August 22, 2019 by the Executive Director.	No exceptions
RATING	☒	☐	☐	☐	☐	The program did not have any youth who were included in the requirements for the SOGIGE indicator. However, the programs policy and procedure do indicate that the elements of the SOGIGE indicator are met by the program. The program did have signage posted in the common areas. Additionally, they have the “zines” around the facility as well. The	No exceptions

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		
						program had a training on SOGIGE on August 15, 2018. For any new staff their process is for them to complete a training of all of their policies during the new hire orientation which includes SOGIGE. Training on Cultural Competency for LGBTQ Youth on the Florida Network Website is also utilized. If there are any youth who are LGBTQ coming into the facility this can also be discussed with staff at their weekly Shelter Case Staffing.	
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 policy in place titled 2.09 Special Populations that was last reviewed August 22, 2019 by the Executive Director.	No exceptions
RATING	☒	☐	☐	☐	☐	The program had three domestic violence (DV) youth in the last six months. All three DV youth did not exceed twenty-one days in the shelter. Data was entered into Netmis and JJIS within twenty-four hours of admission and seventy-two hours of release. Case plans in all three files reflected goals for aggression management and family coping skills. All other services provided were consistent with general CINS/FINS program requirements. The program had one probation respite youth in the last six months. The referral was made by the juvenile probation officer and the length of	No Exceptions

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		
						stay was determined at the time of admission. The length of stay was less than thirty days. Data was entered into NetMIS and JJIS within twenty-four hours of admission and seventy-two hours of release. All case management and counseling needs were considered and addressed. All other services provided were consistent with general CINS/FINS program requirements. There were three intensive case management (ICM) files reviewed. All three youth were court ordered or referred by a case staffing. All files contained at least six direct contacts with the youth and families per month. All three files contained at least six collateral contacts per month. A Child Behavior Checklist (CBCL) was completed within fourteen days of intake and discharge. All files had a self-report assessment completed at intake and every ninety days after. Case plans were strength based and trauma informed focused. The ICM services had a strength-based perspective to help youth and families. The program did not have any youth in the last six months for domestic minor sex trafficking, staff secure, and family and youth respite aftercare services. A practice is in place that meets the requirement of those special populations.	
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement						☒ YES ☐ NO (explain)	No exceptions

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 Indicator 2.10						There is a policy in place titled 2.10 Stop Now and Plan that was last reviewed August 22, 2019 by the Executive Director.	
RATING	☐	☒	☐	☐	☐	There were five SNAP files reviewed, two open and three closed. All five files documented the youth were screened at intake. There was a signed consent form in each file signed by the parent. A needs assessment was completed at intake in each file. A pre CBCL was completed at intake in each file. A pre-Teacher Report Form (TRF) was not completed in any of the files; however, two files had documentation of this form being given to the teacher and attempts to have the form filled out. The other three files did not have this documentation although it was explained the forms were given to the teachers but never received back. A pre TOPSE assessment was completed at intake in each file. A PAT assessment was completed at intake in each file. For the three closed files a post CBCL was completed. A post TRF was not completed. A TOPSE assessment and PAT assessment was completed at discharge in all three files. A SNAP Discharge Report Summary was completed in all three files. There were two sessions for SNAP in Schools reviewed. Both sessions documented weekly attendance sheets with the youth's	Both sessions of SNAP in Schools reviewed did not document a pre evaluation for the teacher and each youth.

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		
						name and signature of the teacher and SNAP facilitator for all thirteen sessions. Both sessions documented the Class Shoot for Your Goal sheet was completed. Both sessions did not document a pre evaluation for the teacher and each youth. Both sessions did document a post evaluation for the teacher and each youth. Both sessions documented one Fidelity Adherence Checklist was completed.	

STANDARD 3: SHELTER CARE

Quality Improvement Indicators	Rating: Explain — Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	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 for Indicator 3.01						☒ YES ☐ NO (explain) A policy is in place titled 3.01 Shelter Environment that was last reviewed August 22, 2019 by the Executive Director.	No exceptions
RATING	☐	☒	☐	☐	☐	A tour of the shelter found the facility to be well maintained and in good repair. Furnishings throughout were in good repair and the shelter was clean. There was no noted graffiti on walls, doors or windows. Lighting was adequate, and no insect infestation was noted. Bathroom and shower areas were clean and well maintained. Both bathrooms had hot and cold water available; all sinks, showers and toilets were operating. A tour of dormitory rooms found each room was clean and well organized. Each youth was assigned a bed with a clean mattress, pillow, linens and blanket. Youth personal belongings are maintained in individual secure lockers located in the day room; youth clothing is maintained in individual lockers assigned to youth within their	A review of mock drills for the past two quarters found a third shift mock drill was not conducted from April to June. 2019.

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		
						dormitory room. Youth personal hygiene products are maintained in an individual plastic container and are housed in a locked closet. Contraband or and hazardous unauthorized objects were not noted within the dormitory rooms. Observation of the activity and school schedules found youth are engaged in meaningful, structured activities and are provided at least one hour of physical activity daily. Daily programming includes opportunities for youth to complete homework and age appropriate books for reading. Schedules are posted in each youth dormitory room as are copies of the grievance procedure, behavior management system, Florida Abuse Hotline number, emergency procedures and client rights and responsibilities. Additional copies of these postings were observed in the day room. A detailed map and egress plan are posted outside of each dormitory room, day room and hallways. Interview with the program manager found youth are offered the opportunity to participate in a variety of faith-based activities such as church and bible study. Youth who do not participate in faith-based activities are offered structured activities such as community outings or outdoor activities. Interview with the program manager found staff are issued a key to the facility upon hire. Staff sign the key log once issued a key and	

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		
						return the key upon resignation from their position. Exterior cameras monitor all perimeter activity. A tour of the perimeter found grounds to be well maintained and free of debris. Garbage receptacles were observed and were covered. Observation of two agency vans found each contained a fully charged fire extinguisher, first aid kit, flashlight, glass breaker and seat belt cutter. One additional agency van was unavailable for observation as it was in for service. Staff vehicles were observed to be locked and secure. A review of documentation found the shelter has a current DCF Childcare license effective February 1, 2019. An annual fire inspection was conducted by the Ft. Myers Fire Department on October 19, 2018; monthly agency drills were conducted with an exit within two minutes or less. Fire extinguishers were observed and were last inspected May 2019 by FYR FYTER. Sprinklers were last inspected October 15, 2019 by Wayne Automatic Sprinklers. The kitchen suppression system was inspected by the Hood Guys August 2019. A current satisfactory Group Care Inspection Report from the Department of Health was observed and is dated October 26, 2018. The last food service inspection report was completed August 3, 2018. The program has requested a current inspection and is awaiting a confirmation date. Observation	

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		
						of the kitchen found all food was appropriately labeled, dated, sealed and stored. Refrigerators and freezers were operating and maintained at appropriate temperatures. All appliances were reported operable and the kitchen was clean and organized. All chemicals were appropriately inventoried and stored securely in the medical room closet. Material Safety Data Sheets were maintained for each item.	
3.02: Program Orientation							
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						☒ YES ☐ NO (explain) A policy is in place titled 3.02 Program Orientation that was last reviewed August 22, 2019 by the Executive Director.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five youth files reviewed, three open and two closed. Each file documented youth received a comprehensive orientation to the program and handbook within twenty-four hours. The program orientation process included a review of disciplinary action, grievance procedure, emergency and disaster procedures, contraband rules, facility layout, room assignment, daily activities, and Florida Abuse Hotline number. Each youth file contained the signature of youth and parent as observed on the Acknowledgement Page located in each youth file. One open youth file documented the youth remains under	No exceptions

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		
						precautionary supervision. One closed youth file documented the suicide alert was discontinued.	
3.03: Youth Room Assignment							
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						☒ YES ☐ NO (explain) A policy is in place titled 3.03 Youth Room Assignment that was last reviewed August 22, 2019 by the Executive Director.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five youth files reviewed, three open and two closed. Each youth file documented a process for youth room assignment to include the initial classification of youth, with consideration given to potential safety and security concerns. The youth intake form documents a review of youth history, status and exposure to trauma, age, gender, history of violence, disability, physical stature, gang affiliation, suicide risk, sexually aggressive behavior, and gender identification. Based upon the findings, youth are assigned to an appropriate room with their preference noted.	No exceptions
3.04: Log Books							
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						☒ YES ☐ NO (explain) A policy is in place titled 3.04 Logbook Requirements that was last reviewed August 22, 2019 by the Executive Director.	No exceptions

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 program uses an electronic logbook to document all activities, incidents and events. All observed entries included the date, names of individuals involved, a description of the event, name and signature of the staff making the entry. Noted entries included youth movement within the program, incidents, youth intake, visitor notification, medication monitoring, vitals, transportation, youth behavior, and staff reporting and exiting their shift. Any errors in documentation were observed to be crossed out with a clear line and initialed and dated by staff.	Observation of the electronic logbook found supervisory and direct care staff inconsistently documented their review of the previous two shifts in the logbook. A review of the current month found no documented supervisory or direct care staff reviews on 9/12/19, 9/13/19, 9/14/19, 9/16/19,9/17/19 and 9/20/19. Findings from indicator 3.06 staff and supervision noted that "One of the days reviewed documented a two-hour gap in the Note Active logbook with no bed checks documented" and the program should have a secondary method to document bed checks if unable to record in the electronic log book.
3.05: Behavior Management Strategies							
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						☒ YES ☐ NO (explain) A policy is in place titled 3.05 Behavior Management Strategies that was last reviewed August 22, 2019 by the Executive Director.	No exceptions
RATING	☒	☐	☐	☐	☐	The program has a behavior management system designed to ensure youth compliance with program rules and change youth behavior and accountability. The system is based upon a token economy of points and phases to encourage a decrease in youth negative behavior and increase positive behavior. During the intake and orientation process youth are educated regarding the	No exceptions

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		
						behavior management system and are provided with a copy of the program handbook which documents the behavior management system for youth reference. Program incentives to encourage positive behavior include community outings, food incentives, prize cabinet, later bedtime and extra phone calls. Incentives are earned based upon youth behavior. Behavioral interventions are applied immediately to address the severity of negative behaviors. Interventions are inclusive of counseling, affording youth time and space and assisting youth consider alternate behaviors. Consequences are applied logically and consistently. Youth are never denied food, clothing, rest, services, contact or exercise. All staff are trained regarding the behavior management system at the time of hire and receive supervision regarding their implementation of the system both individually and during staff meetings.	
3.06: Staffing and Youth Supervision							
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						☒ YES ☐ NO (explain) The agency has a policy in place titled 3.06 Staffing and Youth Supervision that was last reviewed August 22, 2019 by the Executive Director.	No exceptions
RATING	☐	☒	☐	☐	☐	The program maintains the appropriate ratios for staffing of one staff to six youth during awake hours and one staff to	There were three different occasions where there was a gap of over twenty-five minutes in the bed checks.

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		
						twelve youth during sleeps hours. The program has three staff scheduled to work overnights on a regular basis. The program has the staff schedule posted in the staff office where it is visible to all staff. The YCS III also sends a copy of the schedule to staff via text. The program maintains a phone listing of staff who may be available when coverage is needed, right next to the posted schedule. There is also an on-call list with numbers posted. Staff check on the youth every fifteen minutes overnight. However, youth on sight and sound are checked every five minutes. There were ten different overnight shifts checked on the cameras, during the last twenty days, to ensure bed checks were being conducted. There were three different occasions where there was a gap of over twenty-five minutes in the bed checks. One of the days reviewed documented a two-hour gap in the Note Active logbook with no bed checks documented. A secondary method to document these bed checks was not provided. However, after reviewing the cameras it was noted the checks were completed but were not documented. Staff noted there was a problem with the Note Active logbook during that time frame. The other days reviewed documented all bed checks were completed every seven to fifteen minutes.	

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		
3.07: 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 policy in place titled 3.07 Video Surveillance that was last reviewed August 22, 2019 by the Executive Director.	No exceptions
RATING	☐	☒	☐	☐	☐	The program has a video surveillance system that captures photographic images and records the date, time, and location. There is a sign posted at the front door of the shelter documenting cameras are in use. Cameras are installed on the interior and exterior of the building and the cameras are only accessible to designated staff. The program manager has the code for the cameras for review. There are twenty-two cameras around the facility. There is the capability to access information beyond the storage capacity in the case of a third-party review. This is completed by transferring the information via a zip disk. The cameras are reviewed by the program manager every fourteen days. This information is kept in a separate logbook from the daily activity logbook. There is a generator for the building that will operate the camera system in case of a power outage.	The program cameras only have storage for approximately twenty-one days instead of the required thirty days. There was a request for ADT to increase the storage capacity. This occurred on Monday, September 23, 2019, but there has been no increase at this time.

STANDARD 4: MENTAL HEALTH/HEALTH SERVICES

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 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)** The agency has a policy in place titled 4.01 Healthcare Screening Admission that was last reviewed August 22, 2019 by the Executive Director.	No exceptions
RATING	☒	☐	☐	☐	☐	At intake into the facility the staff assess medical needs by completing the CINS/FINS Intake Assessment form which includes a physical health screening and a visual inspection of the youth. The shelter nurse reviews all intakes within five business days. If there is a medical, dental, or mental health condition that exists, the youth care staff will contact the on-call counselor. The on-call counselor or the residential manager will contact the parent/guardian. There were five youth files reviewed, two opened and three closed. All five files documented the CINS/FINS Intake form was completed on the day of admission and reviewed within five days by the shelter nurse. There were two youth with allergies and two youth with a medical condition. These conditions were documented in the file and also entered into the shelters alert system. The shelter has procedures in place for follow-	No exceptions

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		
						up care if it is needed. None of the files reviewed required any type of follow up care or medical referral.	
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.**							
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						☒ **YES** ☐ **NO (explain)** The agency has a policy in place titled 4.02 Suicide Prevention that was last reviewed August 22, 2019 by the Executive Director.	No exceptions
RATING	☐	☒	☐	☐	☐	There were three closed residential files reviewed. All three files contained a suicide risk screening that was completed at the initial intake. All three of the risk screenings were reviewed and signed by a supervisor. All three youth were placed on sight and sound supervision. Youth remained on sight and sound until removed by a non–licensed counselor working under the direct supervision of a licensed counselor. In all three files reviewed the Assessment of Suicide Risk was completed within twenty-four hours of admission. All three files contained observation logs that were maintained the entire time the youth were on suicide precautions. The logs indicated observation every five minutes. The shift supervisor and the clinical director signed all observation logs. All three files reviewed indicated youth were removed	The shelter has a designated sleeping rooms for youth on site and sound supervision, room number three and room number four, so a staff can sit outside the door and monitor the youth. It was observed that a current youth on site and sound supervision was placed in a different room where staff did not have continuous sight and sound supervision of the youth. However, there were five-minute observations of the youth maintained the entire time the youth was in the room. These observations were documented on the observation log and were also observed while reviewing the video surveillance system for over-night bed checks. The three closed files reviewed indicated that room number three was utilized for site and sound supervision in all three of those cases. Staff were conducting five-minute bed checks.

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		
						from suicide precautions and placed on normal supervision levels after the suicide assessment was completed.	
4.03: Medication							
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						☒ **YES** ☐ **NO (explain)** The agency has a policy in place titled 4.03 Medications that was last reviewed August 22, 2019 by the Executive Director.	No exceptions
RATING	☒	☐	☐	☐	☐	The agency has a list of staff who are trained to supervise the administration of medications. The registered nurse (RN) is listed as one of the Super Users of the Pyxis Med-Station, as well as, the residential services manager. The RN distributes any needed medications when onsite. Trained youth care specialists (YCS) with access to the Pyxis Med-Station distribute medications when the RN is not onsite. Trained YCS complete an inventory every shift of controlled medications. This inventory is documented on the youth's Medication Distribution Log (MDL). A perpetual inventory is maintained on each medication as it is given and documented on the MDL. Over the counter (OTC) and prescription medications are stored in the Pyxis Med-Station which is stored in a locked room accessible only to authorized staff. Oral medications are stored separately from topical medications. The shelter has a	No exceptions

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 refrigerator that is locked, and the temperature is set to 46 degrees. The RN trains all staff on the use of the Pyxis Med-Station, Epi Pens and the medication administration process at hire. Training documents were located in the medication room. Medications are verified at admission by contacting the pharmacy. Reports reviewed show that there were no open discrepancies in the Pyxis Med-Station. Staff are aware that discrepancies should be cleared at the end of each shift. A monthly review of Pyxis reports is conducted by the RN. The shelter currently does not accept prescribed injectable medications. There is locked file cabinet in the kitchen where sharps are stored. All sharps are inventoried weekly.	
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)** The agency has a policy in place titled 4.04 Medical/Mental Health Alert Process that was last reviewed August 22, 2019 by the Executive Director.	No exceptions
RATING	☒	☐	☐	☐	☐	The shelter utilizes a color-coded system for medical and mental health alerts. There were five residential files reviewed. All files contained color-coded alert dots that corresponded with identified alerts. All five files contained an alert check list in the youth file. Alerts were also appropriately documented on the alert	No exceptions

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		
						board in the YCS office. Staff were provided sufficient information to recognize and respond to the need for emergency care.	
4.05: Episodic/Emergency Care							
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						☒ **YES** ☐ **NO (explain)** The agency has a policy in place titled 4.05 Episodic/Emergency Care that was last reviewed August 22, 2019 by the Executive Director.	No exceptions
RATING	☒	☐	☐	☐	☐	The program has a practice in place for off-site emergency medical situations. They have not had any off-site medical situations in the last six months. A review of the program's incidents/accidents for the past six months showed one medical incident for a panic attack, 911 was contacted but did not transport the youth to the hospital. The parent was notified of the incident and follow up documentation was in the youths file. First aid kits are located in the nurse's office and dayroom. Shelter staff review the kits on a weekly basis to ensure they are well stocked. The knife-for-life and wire cutters are located on the wall in the laundry room and in the staff office. The shelter conducts emergency medical drills on each shift, each month. There emergency drills were reviewed and were found to be completed for the last six months.	No exceptions