Florida Network for Youth and Family Services
Compliance Monitoring Report for

LSF SW – Oasis
3615 Central Ave., Suite 3
Fort Myers, Florida 33901

Compliance Monitoring Services Provided by

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 2020-2021 at its program office located at 3615 Central Ave., 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 2020 through June 30, 2021.

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; and Samuel Laguerre, Residential Services Manager. The last onsite QI visit was conducted September 25 - 26, 2019.

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

2020-2021 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 3-10-2021

Agency Name: LSF SW – Oasis	**Monitor Name: Ashley Davies, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 3615 Central Ave., Fort Myers, FL 33901**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): March 10 – 11, 2021**

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. 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. Both of these staff have participated as a peer reviewer this 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 and grants for FY 2020- 2021 was provided by the provider. The list includes grant program, funder name, and contract period. 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 reviewed had recent contract/agreement dates.	**No recommendation or Corrective Action.**
Limits of Coverage	☐	☐	☒	☐	☐	Documentation:	**No recommendation or Corrective Action.**

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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**						Insurance provided by Market Global Reinsurance Company. The provider's General Liability insurance provides limits of coverage of $1,000,000 each/$3,000,000 aggregate and $10,000 each for medical expenses. The providers Automobile insurance provides limits of coverage of $1,000,000 combined for each accident. The providers Excess/Umbrella Liability insurance provides limits of coverage of $1,000,000 each/aggregate. The provider's Professional Liability insurance provides limits of coverage of $1,000,000 each/$3,000,000 aggregate. The provider's Abuse/Molestation insurance provides limits of coverage of $1,000,000 each/$3,000,000 aggregate.	

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						Coverage for the above policies is in effect for the current FY 2020-2021, 6/1/2020 – 6/1/2021. 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 are in place signed by the VP of Finance and the CFO with a revision date 6/4/2018. The procedures reviewed appear to be consistent with GAAP and provide for limited internal controls. Procedures are included for general ledger, cost accounting, payroll, petty cash, computer backup, and other relevant financial processes.	**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	☐	☐	☒	☐	☐	Documentation: Detailed General Ledger for the current FY2020-2021, as of 7/1/2020	**No recommendation or Corrective Action.**

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(standard account numbers / separate funds for each revenue source, etc.). **PTV**						to 12/31/2020. Agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS, ICMS, and SNAP programs separately. The Ledgers showed current balances and differences.	
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 and Documentation: 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	☐	☐	☒	☐	☐	Documentation: Reviewed Bank Statements for one account Bank of America operating for	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**						the period July 2020 – December 2020. Successful bank reconciliations were conducted within 6 weeks of receipt of bank statements, comparing ledger balances with balances reflected on the bank statements. Reconciliations were signed by two parties.	
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**	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	**No recommendation or Corrective Action.**
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: Provider submitted evidence of payroll taxes and deposits for quarters three and four of 2020. A Collection Details report showed funds deposited every two weeks and an EFTPS Paid Tax report showed all payments made.	**No recommendation or Corrective Action.**

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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 12/31/2020. The report tracks all budget categories by current period actual and current period budget - contract separately. Variances if applicable are identified. CINS/FINS, ICMS, and SNAP are tracked separately. 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 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: Financial audit was conducted for the fiscal year beginning June 30, 2020 – 2019 by RSM US LLP. A letter dated December 28, 2020 stated no corrective action was needed. A copy was submitted directly to the Florida Network of Youth and Family Services.	**No recommendation or Corrective Action.**

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	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: The agency provided multiple Policies and Procedures. There were no changes in Confidentiality and Security protocols. The policies have been applied consistently across the required areas that include Data Back Up Systems; Information Security; and Confidentiality. Policies are signed by the CEO and last reviewed 8/31/2020.	**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, **the 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/Southwest – Oasis
CINS/FINS Program

March 10 – 11, 2021

Compliance Monitoring Services Provided by

FOREFRONT

Quality Improvement Review

Lutheran Services Florida/Southwest – Oasis – March 10 – 11, 2021
Lead Reviewer: Ashley Davies

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, Gender 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	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: 96.55%
Percent of indicators rated Limited: 3.45%
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 - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services

Tonya Gittens – Department of Juvenile Justice

Brittany Brown – Children's Home Society

Sarah Mann – Safe Children Coalition

Erik Kline – Family Resources

Quality Improvement Review

Lutheran Services Florida/Southwest – Oasis – March 10 – 11, 2021
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, and (3) Shelter Care/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2020/Jan 2021).

Persons Interviewed

- ☐ Chief Executive Officer
- ☐ Chief Financial Officer
- ☐ Chief Operating Officer
- ☒ Executive Director
- ☐ Program Director
- ☒ Program Manager
- ☐ Program Coordinator
- ☒ Clinical Director
- ☒ Counselor Licensed
- ☐ Case Manager
- ☐ Counselor Non-Licensed
- ☐ Advocate
- ☒ Direct – Care Full time
- ☐ Direct – Part time
- ☐ Direct – Care On-Call
- ☐ Intern
- ☐ Volunteer
- ☐ Human Resources
- ☐ Nurse – Full time
- ☒ Nurse – Part time

1# Case Managers
1 # Program Supervisors
0 # Food Service Personnel
1 # Healthcare Staff
0 # Maintenance Personnel
0 # 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
- ☒ List of Supplemental Contracts
- ☐ Vehicle Inspection Reports
- ☐ Visitation Logs
- ☒ Youth Handbook

5 # Health Records
5 # MH/SA Records
43 # Personnel /Volunteer Records
10 # Training Records
7 # Youth Records (Closed)
3 # Youth Records (Open)
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

Due to COVID-19, this review was conducted **virtually.**

Quality Improvement Review

Lutheran Services Florida/Southwest – Oasis – March 10 – 11, 2021
Lead Reviewer: Ashley Davies

Monitoring Purpose:

The purpose of this monitoring is to provide an annual quality improvement program review. This is to verify the agency adheres to all current CINS/FINS standards and contract compliance requirements for residential and non-residential services.

Strengths and Innovative Approaches

The Stop Now and Plan (SNAP) program continues to be fully implemented in Circuit 20, a five-county area. Contract goals for last fiscal year were mostly met with the exception of not fully completing one SNAP in Schools session, which was one group shy of completion due to COVID school shutdowns. The program is staffed with two full-time employees with two part-time facilitators. Lutheran Services Florida SW Oasis continues to have the SNAP facilitator part-time positions available to Youth Care Specialist (YCS) and counseling staff at an enhanced rate of pay. This also provides YCS staff growth in their professional development. SNAP's capacity to serve in Charlotte County has grown so they are looking to hire more part-time facilitators. The SNAP in schools has continued to grow in Charlotte county.

The Intensive Case Management (ICM) team has had some significant turnover since the last QI review. This team has worked very hard and has overproduced since the start of the fiscal year.

Of the currently employed CINS/FINS Counselors, there are three registered Clinical Social Work (CSW) interns.

In the last year, the agency has promoted from within the CINS/FINS program. They believe adamantly that staff development is critical to the effective running of their programs. A YCS II was promoted to YCS III (Shelter Supervisor) and has become a certified Train the Trainer for Managing Aggressive Behavior. A YCS I was prompted to YCS II (first shift lead) after many years of service. Another YCS I was promoted to a YCS II (second shift lead). A YCS I was recently promoted to a CINS/FINS Counselor I after obtaining their bachelor's degree. A Counselor was promoted from CINS/FINS Counselor II to Lead Clinical Counselor.

The pandemic has allowed the program to get creative in how services are delivered and has enabled them to stay connected with families despite the limitations of being COVID safe. At the Oasis Youth Shelter, staff got together and created a prom-like experience for youth residing at the shelter during prom season. Their outreach efforts also expanded into social media platforms and other "outside of the box" opportunities. The SNAP and community counseling team had an LSF CINS/FINS table at multiple Pop Warner games in various communities over the summer and the beginning of school months. The team also did outreach in several Wal-Mart parking lots in which they passed out flyers and spoke to families in the community. They were able to closely connect with the Lee County School Resource Officers and other members of the Lee County Sheriff's Office as well as the Fort Myers Police Department to make their information more accessible to officers who are encountering families in the community by creating information business style cards specifically for the officers. Their strong partnerships in the Charlotte County Sheriff's Office afforded them the opportunity to be a part of a Human Trafficking workgroup that was spearheaded by a Charlotte County Sheriff's Officer who is assigned to the runaway unit and the Clinical Director. As a result, they have seen an increase

in referrals from law enforcement for runaway youth. They were able to establish a partnership with the National Alliance on Mental Illness (NAMI) of Collier County to be a referral source for both NAMI and the CINS/FINS program as well as have a staff of NAMI to be a part of their Case Staffing Committee in Collier County.

The program continues to employ a “Child Welfare” Case Manager that oversees Case Management Organization (CMO) youth for Oasis Youth Shelter initial placement and placement transition from the shelter to a more permanent placement. This Case Manager works mainly with the CMO youth at the shelter. They work in partnership with the CMO Case Manager, placement specialists, and other involved parties like the Guardian Ad Litem. The intent of this position is to assist the CMO Case Manager and placement staff with identifying and transitioning the youth timely to appropriate placements as well as working with the youth while they reside at the shelter. This Case Manager is part of the Oasis team and is housed at the shelter. This Case Manager has been a consistent SNAP facilitator for the Lee County boys groups and does a remarkable job having a positive impact on the SNAP youth. In addition, this Case Manager also coordinates case management tasks for the CINS youth at the shelter.

The NoteActive electronic logbook continues to be utilized in the shelter. They have recently expanded their daily operations within NoteActive including implementing bed checks via scanning.

In January, the shelter became aware that the youth tested positive for COVID-19 after the parent took them to a doctor on or about January 27, 2021.

From that point on, several youths and staff came down with the illness, and the program was forced to think outside the box. Several negative youths were brought to Lippman Youth Shelter. The youth that remained in Oasis Youth Shelter were youth the parents refused to take back until they were negative. Two staff tested positive; however, had no symptoms.

These two staff essentially lived at the shelter with the three youth for a week. The Shelter Manager checked on them daily and provided all necessary items. These two staff stayed at the shelter twenty-four seven from January 28 through February 4, 2021. The shelter was then professionally sanitized and normal shelter operations resumed.

Narrative Summary

Lutheran Services Florida SW Oasis Youth Shelter is managed by an executive director who oversees a shelter manager and a clinical director. The program's administrative department also includes a Quality Assurance Specialist, an Administrative Assistant II, and a Clinical Director. At the time of the review, there were five vacant Youth Care Specialist (YCS) I full-time positions and nine (9) vacant YCS I temp positions.

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.

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, one Shelter Case Manager, and a Youth and Community Engagement Coordinator. One of the Counselors is a Licensed Mental Health Counselor (LMHC) and the other Counselor is a master's level counselor who is a Registered Clinical Social Worker (CSW) intern. There were no vacant positions in the residential counseling program at the time of the review.

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 six Counselors. Out of the six Counselors, one is a master's level Counselor who is a Registered Mental Health (MH) intern and the other five are bachelor's level Counselors. At the time of the review, there were two Counselor positions vacant and a Lead Case Manager position vacant.

The non-residential program also offers Intensive Case Management Services (ICMS) and Stop Now and Plan (SNAP) services. ICMS is provided by an ICMS Manager and an ICMS Coordinator. The ICMS Manager is a master's level staff and the ICMS coordinator is a bachelor's level staff. SNAP services are provided by the SNAP Site Coordinator, a SNAP Case Manager, and two SNAP Facilitators. At the time of the review, there were also two SNAP Facilitator positions vacant. One SNAP Facilitator, the SNAP Case Manager, and the SNAP Site Coordinator are bachelor's level staff. The SNAP Site Coordinator and one SNAP Facilitator are also Clinical Social Worker (CSW) interns. The second SNAP Facilitator is a master's level staff. The Clinical Director oversees both ICMS and SNAP services. In addition to ICMS and SNAP, the program has also provided domestic violence and probation respite services during this review period.

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.

Lutheran Services Florida SW Oasis Youth Shelter residential program is overseen by a Residential Services Manager who oversees all shelter staff. The shelter is led by a Youth Care Specialist (YCS) III who oversees all YCS II and YCS I staff. The shelter runs three shifts. Each shift is led by a YCS II. The first shift has five YCS I and four vacant YCS I positions. The second shift has three YCS I and six vacant YCS I positions. The third shift has two YCS I and four vacant YCS I positions.

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 five CINS/FINS youth in the shelter.

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, a Shelter Case Manager, and a Youth and Community Engagement Coordinator. One of the Counselors

is a Licensed Mental Health Counselor (LMHC) and the other Counselor is a master's level counselor who is a Registered Clinical Social Worker (CSW) intern.

All youth are screened for suicide at intake using the six approved questions on the CINS Intake Assessment form. If youth receives a positive screening, they are placed on sight and sound supervision until seen and assessed by a qualified mental health professional. All staff receives 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-Station4000 Medication Cabinet. Refresher training is provided 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 completes shift-to-shift inventories of all controlled medications and maintains perpetual inventories of all other medications.

<u>The overall findings for the QI Review for Lutheran Services Florida/Southwest - Oasis are summarized as follows:</u>

Standard 1:

This standard has a total of seven indicators regarding management accountability. Six of the seven indicators were rated satisfactory. Indicator 1.03 Incident Reporting was rated limited. There were exceptions noted in indicator 1.04 Training Requirements due to none of the staff completing the DOJ Civil Rights and Federal Funds training and three staff completing some training required in the first 90 days of employment late.

Standard 2:

This standard has a total of ten indicators that relate to intervention and case management. All ten indicators were rated satisfactory. There was an exception noted in indicator 2.03 Case/Service Plan due to one file not having a parent signature on the Service Plan.

Standard 3:

This standard has a total of seven indicators regarding shelter care. All seven indicators were rated satisfactory. There was an exception noted in indicator 3.04 Log Books due to all staff not consistently reviewing the logbook each shift and making an entry stating they reviewed the previous two shifts with the dates reviewed.

Standard 4:

This standard has a total of five indicators regarding mental health and health services. All five indicators were rated satisfactory. There was an exception noted in indicator 4.05 Episodic/Emergency Care due to off-site emergency medical care incidents not being documented on the program's Episodic Care Log.

Quality Improvement Review

Lutheran Services Florida/Southwest – Oasis – March 10 – 11, 2021
Lead Reviewer: Ashley Davies

Summary of Deficiencies resulting in Limited or Failed Rating (If Applicable):

Standard 1: Indicator 1.03 Incident Reporting was rated limited due to two incidents that should have been reported to the CCC and were not. These two incidents were reported and accepted by the CCC when discovered during the review.

Quality Improvement Review

Lutheran Services Florida/Southwest – Oasis – March 10 – 11, 2021
Lead Reviewer: Ashley Davies

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators:	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	Review Based Upon Document Source	Notes Explain any items that have any deficiencies, exceptions or are 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 X NO (explain)** The agency has a policy in place titled 1.01 Background Screening of Employees, Interns, and Volunteers that addresses the requirements of this indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation to for staff hired with a non-passing/low score.	**X**					A total of twelve new staff were hired since the last QI review. Six of the staff met the criteria for a pre-screening assessment. The agency uses the Predictive Index tool. All six staff had a Predictive Index completed prior to date of hire.	
Background screening completed prior to hire/start date or exemption obtained prior to working with youth (if rated ineligible) for new hires, volunteers/interns, and contractors	**X**					A total of twelve new staff, twenty-one interns, and one volunteer were hired since the last QI review. All thirty-four staff were background screened prior to hire.	
Five-year re-screening completed every 5 years from initial date of hire	**X**					There were a total of nine staff applicable for a five-year rescreening during this review period. All nine	

						staff had a re-screening completed prior to the initial date of hire.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**X**					The agency submitted the Annual Affidavit of Compliance with Level 2 Screening via email to the Background Screening Unit on 1/11/2021.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**X**					Documentation of approval of E-Verify work eligibility was provided for all twelve new staff hired.	
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 X NO (explain)** The agency has a policy in place titled 1.02 Provision of an Abuse Free Environment that addresses the requirements of this indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Abuse Free Environment							
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**X**					The program maintains a code of conduct which prohibits the use of physical abuse, profanity, threats, or intimidation that all staff must adhere to. This is reviewed with staff at hire.	
Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	**X**					Child Abuse telephone number was observed during the virtual tour to be posted in the lobby and in the dayroom of the shelter.	
Youth were informed of the Abuse and Contact Number (see youth survey results)	**X**					A review of five residential files confirmed youth were informed of the Abuse Hotline number during orientation. The youth initialed and signed the orientation checklist documenting a review of the Abuse Hotline information.	
Management takes immediate action to address any incidents of threats or abuse	**X**					The program reported there were no incidents of abuse or threats identified and/or reported during the review period needing management action.	
Grievance Process							
Agency has a formal grievance process	**X**					A review of the program's policy confirmed the agency has a formal grievance process in place.	

Locked box accessible to only management and available to youth in a common area	**X**					During the virtual tour it was observed that the program has an accessible grievance box that is locked and located in the dayroom. The supervisor has a key to the box, and it is checked daily.	
Direct care does not handle the complaint/grievance unless assistance is asked for by the youth. Program director/supervisor will have access to and manage grievances unless it is towards themselves.	**X**					The program's policy for grievance procedures states direct care staff will not handle grievances. All grievances reviewed were signed and resolved by a supervisor. Only the supervisors have a key to the grievance box.	
72-hour resolution requirement by management. If this does NOT occur within the 72 hour period, there is sufficient documentation explaining the cause for the delay in resolution.	**X**					There were eleven grievances filed in the last six months. All eleven grievances were resolved within seventy-two hours by a supervisor.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						**YES X NO (explain)** The agency has a policy in place titled 1.03 Incident Reporting that addresses the requirements of this indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident		**X**				There were twelve CCC reports reviewed during the last six months. Three of the twelve reports were non-COVID related incidents. The remining nine reports were due to a staff or youth testing positive for COVID. The three non-COVID related incidents were reported to the CCC within two hours of the program learning of the incident.	**Exception:** Upon a review of the program's internal incident reports for the last six months it was discovered there were two incidents that should have been reported to the CCC and were not. One incident was a youth going off-site for emergency medical treatment and the other incident was a youth cheeking their

							medication and hiding it in their bedroom. Both of these incidents were called into the CCC during the review and were accepted.
The program completes follow-up communication tasks/special instructions as required by the CCC	X					All three non-COVID related incidents reported to the CCC documented follow-up communication and tasks were completed as required and the reports were successfully closed.	
Incidents are documented in the program logs and on incident reporting forms	X					All three non-COVID related incidents reported to the CCC were documented in the program's log book and also documented on incident reporting forms.	
All incident reports are reviewed and signed by program supervisors/directors	X					All incident reports reviewed were signed by the person completing the report and by a supervisor and director.	
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 X NO (explain)** The agency has a policy in place titled 1.04 Training Requirements that addresses the requirements of this indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
First Year Direct Care Staff							
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. *(Staff hired before January 1st were required to complete no later than December 31, 2020)*		X				There were ten staff training files reviewed.	**Exception:** None of the training files reviewed documented the staff completed the DOJ Civil Rights and Federal Funds training.

All staff receives all mandatory training during the first 90 days of employment from date of hire.		**X**				There were five staff training files reviewed for first year training requirements. Two of the five staff completed all mandatory training required during the first 90 days of employment.	**Exception:** In the remaining three training files two staff documented two trainings completed outside the 90 day time frame and one staff documented three training completed outside the 90 day time frame.
All staff completes all mandatory Florida Network and SkillPro training during the first-year employment.	**X**					All five staff competed all required SkillPro trainings. All five staff also completed all additionally required trainings during the first year of employment. Each staff documented over the 80 required training hours. One staff still had approximately five months remaining in their first year training cycle to receive additional trainings. The other remaining four staff had completed their first year training cycle.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training	**X**					There was one Non-Licensed Mental Health Clinical staff file reviewed.	
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**X**					The non-licensed mental health file that was reviewed had all five supervised Suicide Assessments required within one year, documented 20 hours of Suicide Risk Assessment training, and was signed by a licensed mental health professional.	
In-Service Direct Care Staff							

Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**X**					There were five staff training files reviewed for in-service training requirements. All five staff documented more than the required 40 hours of annual training and all required trainings for their last completed training cycle.	
Required Training Documentation							
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.	**X**					All ten training files reviewed contained a spreadsheet documenting all trainings, date completed, and hours. Also, training files included any related documentation such as training certificates, sign-in sheets, and training worksheets.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						**YES X NO (explain)** The agency has a policy in place titled 1.05 Analyzing and Reporting Information that addresses the requirements of the indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**X**					The program provided quarterly case record review reports for both residential and non-residential. The reviews were conducted in September and December 2020.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**X**					There was documentation provided through monthly staff meeting minutes to show incidents, accidents, and grievances are reviewed monthly at the staff meetings.	
The program conducts an annual review of customer satisfaction data	**X**					The agency prepares a monthly PQI report at which time all customer satisfaction surveys are reviewed and documented in the report. This information is shared with the Quality Assurance Specialist and the Executive Director.	

The program conducts an annual review of outcome data and (if applicable) there is evidence of annual reconciliation that occurs through communication from the Florida Network via email or phone call when corrections are needed and the information is corrected and submitted within the requested timeframes.	X					The Executive Director, Clinical Director, and Shelter Manager receive a monthly report on all outcome data for the FNYFS. This information is then reviewed and shared with all staff during the monthly staff meetings and clinical team meetings. The program reported an annual reconciliation was just completed with the Florida Network in January 2021.	
The program conducts a monthly review of NetMIS data reports.	X					NetMIS data reports are reviewed monthly by the Clinical Director.	
The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that they have reconciled any differences noted.	X					The Clinical Director reviews information in JJIS and NetMIS monthly to ensure accuracy of data entry and collection. Any differences are reconciled at that time by the Clinical Director.	
The program has a process in place to review and improve accuracy of data entry & collection	X					To ensure data is entered into JJIS and NetMIS accurately the Administrative Assistant and Intake Screener primarily enter data into the systems. They will review the program screening for completion and accuracy. Information will be entered into JJIS as documented on the screening. Information will then be entered into NetMIS including JJIS ID and FLN number. The Administrative Assistant or Intake Screener will then complete the checklist on the Screening and Discharge Summary form to include verification of data entered for JJIS ID, intake and release date, and reason for release.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	X					There was documentation through monthly staff and clinical team meeting minutes that findings are communicated to staff and stakeholders.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	X					A PQI Monthly Spreadsheet and Companion report is created with all information discussed at the monthly staff and clinical team meetings, all outcome data, all NetMIS data, customer satisfaction data 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.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES X NO (explain)** The agency has a policy in place titled 1.06 Client Transportation that addresses the requirements of this indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**X**					The program provided a list of staff approved to transport youth.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**X**					There was documentation all drivers had a valid Florida driver's license and are covered under the agency's insurance policy.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**X**					The programs policy titled 1.06 Client Transportation prohibits transporting a youth without another passenger in the vehicle. There are provisions in place in case a 3rd party is not present in the vehicle.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**X**					There were numerous single client transports each month for the last six months due to school transports. The Vehicle Transportation Logs documented supervisor approval; however, did not document a date or time of the approval. So, a sample of single client transports were reviewed for each month for the last six months for documentation in the log book. There were three transports randomly reviewed each month and all transports were found documented in the log book with supervisor approval prior to the transport taking place.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	**X**					The 3rd party present on transports reviewed for the last six months was either an agency staff member or another youth.	

There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**X**					Vehicle Transportation Logs were reviewed for the last six months and documented the date, time, mileage, number of passengers, destination, and drivers initials. All Transportation Logs were filled out in their entirety.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						**YES X NO (explain)** The agency has a policy in place titled 1.07 Outreach Services that addresses the requirements of this indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program has a lead staff member designated to participate in local DJJ board and council meetings with evidence that includes minutes of the event or other verification of staff participation	**X**					Documentation through emails and meeting notes was provided to show a representative from the program attended the last two CAB meetings for circuit 20 on September 16 and December 16, 2020.	
Outreach and prevention services are provided by designated staff and include increasing community awareness, offering informational and educational CINS/FINS services to youth and families.	**X**					The program provided evidence of outreach events by providing the NetMIS outreach report which includes title of event, date of event, number of youth and adults in event, purpose of event, and what area event took place in the community. The outreach activities were conducted at local schools and community events.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**X**					The program provided twenty-eight interagency agreements. Agreements were with mental health providers, local schools, universities, police departments, sheriff's departments, local homeless coalitions, and local court system. The agreements included services provided.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						**YES X NO (explain)** The agency has a policy in place titled 2.01 Screening and Intake that addresses the requirements of this indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Shelter youth: Eligibility screening is completed immediately for all shelter placement inquiries. If staff on duty cannot complete the screening, an on-call supervisor is contacted and eligibility is determined within 30 minutes from initial inquiry.	X					There were five residential shelter files reviewed, one open and four closed. All five files documented an eligibility screening was completed immediately.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the NetMIS form	X					There were five community counseling files reviewed, two open and three closed. All five files documented an eligibility screening was completed within three days of the referral.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	X					All ten files documented the youth and parent/guardian received, in writing, available services options, rights and responsibilities, and brochure.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	X					All ten files documented the youth and parent/guardian were provided information on possible actions occurring through involvement with CINS/FINS services and the grievance procedure.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						**YES X NO (explain)** The agency has a policy in place titled 2.02 Needs Assessment that addresses the requirements of this indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Completion of Needs Assessment							
Shelter Youth: Needs Assessment initiated within 72 hours of admission	X					There were five shelter files reviewed, one open and four closed. All five files documented the Needs	

						Assessment was initiated within 72 hours of admission.	
Non-Residential youth: Needs Assessment is done within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**X**					There were five community counseling files reviewed, two open and three closed. All five files documented the Needs Assessment was completed within two to three face-to-face contacts.	
Needs Assessment is conducted by a bachelor's or master's level staff member	**X**					All ten Needs Assessments were completed by a bachelor's or master's level staff member.	
Needs Assessment includes a supervisor's review signature upon completion	**X**					All ten Needs Assessments were signed by a supervisor upon completion.	
Suicide Risk as a Result of the Needs Assessment							
Youth was identified with an elevated risk of suicide as a result of the Needs Assessment			**X**			None of the files reviewed documented the youth identified with an elevated risk of suicide as a result of the Needs Assessment.	
If yes, the youth was referred for an Assessment of Suicide Risk conducted by or under the direct supervision of a licensed mental health professional			**X**			None of the files reviewed documented the youth identified with an elevated risk of suicide as a result of the Needs Assessment.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES X NO (explain)** The agency has a policy in place titled 2.03 Case/Service Plan that addresses the requirements of this indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Case/Service plan is developed within 7 working days of Needs Assessment	**X**					There were ten files reviewed, five shelter files reviewed, one open and four closed, and five community counseling files, two open and three closed. All ten files had a Service Plan developed within seven working days of the Needs Assessment.	
Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the Needs Assessment		**X**				All ten Service Plans reviewed included individualized and prioritized needs and goals identified by the Needs Assessment, service type, frequency and location, persons responsible, and target dates for completion. Of the ten files reviewed, seven files include actual goal completion dates while one shelter	**Exception:** One closed shelter file did not have a parent signature on the Service Plan. There was no

2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated						file and two community counseling files are still open. All ten Service Plans had the signature of the counselor, supervisor, and youth. Nine of the ten Service Plans had the signature of the parent.	documentation in the progress notes if consent was obtained verbally. The parent did participate in one family session and was made aware of Service Plan goals and progress.
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**X**					All five community counseling files were applicable for 30 day reviews. All of the 30 day reviews in these files were completed as required. The five shelter files reviewed were not applicable for 30 day reviews due to not being in the program long enough.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						**YES X NO (explain)** The agency has a policy in place titled 2.04 Case Management and Service Delivery that addresses the requirements of this indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Counselor/Case Manager is assigned	**X**					There were ten files reviewed, five shelter files, one open and four closed, and five community counseling files, two open and three closed. All ten files had a counselor assigned.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families	**X**					All ten files establish referral needs and coordinated referrals to services based upon the ongoing assessment of the youth's/family's problems and needs, coordinated service plan implementation, monitored youth's/family's progress in service, and provided support to families. Five out of ten files were applicable and documented monitoring out-of-home placement. Two applicable files referred the youth and family to the case staffing committee. None of the files were applicable for accompanying youth/guardian to court hearings and related appointments. Four of the ten files were applicable and referred the youth/family for additional services. All ten files provided case monitoring and reviews. All seven applicable files	

5. Monitors out-of-home placement (if necessary) 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit						provided case termination documentation. There were seven files applicable for providing follow-up after 30 of exit and six files after 60 days of exit. All follow-up calls were completed as required.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**X**					The program has written agreements with Bay Area Youth Services Florida, Big Brothers and Big Sisters of Sun Coast Florida, Children's Network of SW Florida, Continuum of Care Lee County, Hanley Centers Foundation, Human Trafficking Awareness Partnership Inc, Salus Care, and local schools and universities, local police and sheriff's departments, and local homeless coalitions. The agreements allow for a comprehensive referral process.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						**YES X NO (explain)** The agency has a policy in place titled 2.05 Counseling Services that addresses the requirements of this indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth and families receive counseling services, in accordance with the youth's case/service plan, to address needs identified during the assessment process	**X**					There were ten files reviewed, five shelter files, one open and four closed, and five community counseling files, two open and three closed. Service plans and case notes maintained demonstrated all ten youth received counseling services to address needs identified during the assessment process.	

Quality Improvement Review

Lutheran Services Florida/Southwest – Oasis – March 10 – 11, 2021
Lead Reviewer: Ashley Davies

Shelter Program							
Shelter programs provides individual and family counseling	**X**					All five shelter files reviewed demonstrated individual and/or family counseling was offered.	
Group counseling sessions held a minimum of five days per week	**X**					All five shelter files reviewed documented group sessions at least five days per week.	
Group counseling sessions consist of: a. Length of at least 30 minutes b. Opportunity for youth engagement c. Clear and relevant topic (informational/developmental/ educational) d. Clear leader or facilitator	**X**					All groups reviewed were at least 30 minutes in length, had an opportunity for engagement, had a clear and relevant topic, and had a clear leader.	
Community Counseling							
Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, or the local provider's counseling office.	**X**					All five community counseling files reviewed documented therapeutic services were provided by agency staff and were documented in the case notes. Referral needs were established and provided to all five youth.	
Counseling Services							
Reflect all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up	**X**					All ten files reviewed documented coordination between presenting problems, the needs assessment, service plan, service plan reviews, case management, and follow-up.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	**X**					An individual youth file was maintained for all ten youth files reviewed.	
Case notes maintained for all counseling services provided and documents youth's progress	**X**					All ten youth files included case notes that documented services provided including counseling and the youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance	**X**					A sample of case records are reviewed quarterly. Quarterly case record reviews were reviewed from September 2020 and December 2020. A supervisor also signs all screening, assessment, and treatment	

						paperwork in each file to ensure staff performance is adequate.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						**YES X NO (explain)** The agency has a policy in place titled 2.06 Adjudication/Petition Process that addresses the requirements of the indicator. The policy was last reviewed on January 6, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Case Staffing Initiation and Notifications							
If parent/guardian initiates, staffing is held within 7 days	**X**					There were four case staffings reviewed. None of the staffings were initiated by the parent.	
The youth, family and case staffing committee are contacted within a minimum of five working days a. Notification to youth/family no less than 5 working days prior to staffing b. Notification to committee no less than 5 working days prior to staffing	**X**					There were four case staffings reviewed. All four case staffings documented the family and committee were notified at least five working days prior to the staffing.	
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**X**					All four staffings included the CINS/FINS provider and a school representative.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**X**					A law enforcement and mental health representative were present at all four case staffings.	
The program has an established case staffing committee, and	**X**					The program has an established committee that meets on a regular basis.	

has regular communication with committee members							
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**X**					The program has policy 2.06 Adjudication/Petition Process in place and has a committee that meets on a regular basis.	
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services	**X**					In all four case the youth and family were provided a revised plan for services.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**X**					In all four cases a written report was provided to the parent within seven days of the staffing outlining recommendations and reasons for the recommendations.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family					**X**	None of the four files reviewed were applicable for judicial intervention.	
Case Manager/Counselor completes a review summary prior to the court hearing					**X**	None of the four files reviewed were applicable for judicial intervention.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						**YES X NO (explain)** The agency has a policy in place titled 2.07 Youth Records that addresses the requirements of the indicator. The policy was last reviewed on January 6, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
All records are clearly marked 'confidential'.	**X**					All ten youth files reviewed were marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**X**					All files were maintained in a locked file cabinet that was marked confidential located in the staff office area.	
When in transport, all records are locked in an opaque container marked "confidential"	**X**					The program uses a locked, black, opaque case that is marked confidential to transport files.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**X**					All files were maintained in a consistent manner and were neat and orderly making information easy to access.	

Quality Improvement Review

Lutheran Services Florida/Southwest – Oasis – March 10 – 11, 2021
Lead Reviewer: Ashley Davies

Provider has a written policy and procedure that meets the requirement for Indicator 2.08						**YES X NO (explain)** The agency has a policy in place titled 2.08 Sexual Orientation, Gender Identity, Gender Expression that addresses the requirements of this indicator. This policy was last reviewed on January 6, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Use of youth's preferred name/ pronoun: a. Youth are addressed according to their preferred name and gender pronouns b. Youth's preferred name and gender pronouns are used in logbook and on all outward-facing documents and census boards			**X**			A review of the Florida Network's SOGIE Report as of March 8, 2021 and an interview with the Executive Director confirmed there have been no youth who have fallen under the requirements of this indicator since the last Quality Improvement review.	
Youth in need of specialized support is referred to qualified resources (as applicable)			**X**			A review of the Florida Network's SOGIE Report as of March 8, 2021 and an interview with the Executive Director confirmed there have been no youth who have fallen under the requirements of this indicator since the last Quality Improvement review.	
Youth preference is considered and documented for room assignment and youth is not roomed in isolation due to sexual orientation, gender identity, or gender expression			**X**			A review of the Florida Network's SOGIE Report as of March 8, 2021 and an interview with the Executive Director confirmed there have been no youth who have fallen under the requirements of this indicator since the last Quality Improvement review.	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression			**X**			A review of the Florida Network's SOGIE Report as of March 8, 2021 and an interview with the Executive Director confirmed there have been no youth who have fallen under the requirements of this indicator since the last Quality Improvement review.	
The agency has signage and brochures/publication placed in common areas indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression	**X**					A virtual tour of the facility showed signage posted in the lobby area, offices, hallways, and dayroom of the facility.	

Quality Improvement Review

Lutheran Services Florida/Southwest – Oasis – March 10 – 11, 2021
Lead Reviewer: Ashley Davies

Provider has a written policy and procedure that meets the requirement for Indicator 2.09						**YES X NO (explain)** The agency has a policy in place titled 2.09 Special Populations that addresses the requirements of this indicator. The policy was last reviewed on January 6, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Staff Secure							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO** **X**	**N/A**			The provider has not served any youth meeting the criteria for staff secure since the last QI review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**X**					The program's policy titled 2.09 Special Populations covers all requirements for staff secure services.	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services			**X**				
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth			**X**				

c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift							
Agency provides a written report for any court proceedings regarding the youth's progress			**X**				
Domestic Minor Sex Trafficking (DMST)							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO X**	**N/A**			The provider has not served any youth meeting the criteria for DMST since the last QI review.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements			**X**				
Services provided to these youth specifically designated services designed to serve DMST youth			**X**				
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?			**X**				
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond			**X**				

seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)							
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter			**X**				
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements			**X**				
Domestic Violence							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES** **X**	**NO**	**N/A**				
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth admitted to DV Respite placement have a pending DV charge and have evidence of being screened by JAC/Detention, but do not meet criteria for secure detention	**X**					There were three files reviewed, two closed and one open. All three files had a face sheet indicating a pending DV charge and all three were screened by the JAC and did not meet criteria for secure detention.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**X**					All three files had evidence of data entry within three business days of intake and the two closed files also had data entered within three business days of discharge.	
Youth in program do not have length of stay in DV Respite placement that exceeds 21 days. If more than 21 days, documentation exists in youth	**X**					Only one of the three files exceeded 21 days in the program and there was evidence the youth was transitioned to a CINS/FINS bed on the 21st day.	

file of transition to CINS/FINS or Probation Respite placement, if applicable.							
Case plan in file reflects goals focusing aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home	**X**					All three files had Service Plans that focused on anger management and family coping skills.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**X**					All three youth received all other general CINS/FINS required services.	
Probation Respite							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES** **X**	**NO**	**N/A**				
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
All probation respite referrals are submitted to the Florida Network.	**X**					There was one closed probation respite file reviewed. There was documentation a referral was submitted to and approved by the Florida Network.	
Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status	**X**					The referral came from DJJ Probation and the youth was on probation.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**X**					There was evidence of data entry within three business days of intake and discharge.	
Length of stay is no more than fourteen (14) to thirty (30) days? (Placement beyond thirty (30) days requires the approval of the JPO and/or CPO)	**X**					The youth were in the program between 14 to 30 days and did not stay in the program beyond 30 days.	

All case management and counseling needs have been considered and addressed	**X**					All case management and counseling needs identified were addressed.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**X**					The youth received all other general CINS/FINS required services.	
Intensive Case Management (ICM)							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES** **X**	**NO**	**N/A**				
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth receiving services was court ordered or referred by case staffing committee	**X**					There were four ICM files reviewed, three open and one closed. All four youth were either referred by the case staffing committee or were court ordered.	
Services for youth and family include: a. Four (4) direct contacts per month b. Four (4) collateral contacts per month	**X**					All four files documented at least four direct contacts and four collateral contacts each month.	
Assessments include: a. A Child Behavior Checklist (CBCL) is completed within 14 days of intake and at discharge (if applicable) b. An approved self-report assessment that was completed at intake c. An approved self-report assessment that was completed every 90 days following intake and at discharge (if applicable)	**X**					All four files documented a Child Behavior Checklist (CBCL) was completed within fourteen days of intake. All had evidence of a Youth Self-Report assessment completed at intake and the three applicable files had one completed every 90 days. One youth had not yet been in the program 90 days. The one closed file had a CBCL and Youth Self-Report assessment completed at discharge.	
Case plan demonstrates a strength-based, trauma-informed focus	**X**					All case plans demonstrated a strength-based, trauma-informed focus.	

Agency has evidence that ICMS has a strength-based perspective in one or more of the following areas; engaging the family, advocating on their behalf, initiating change agent activities, helping to access supports in the community, teaching problem solving skills, modeling productive behaviors, and/or successful completion of youth and family developmental milestones	**X**					All four files contained documentation of engaging the family, advocating on behalf of the family, helping access support in the community, teaching problem solving skills, and modeling productive behavior.	
Family and Youth Respite Aftercare Services (FYRAC)– Non-residential Only							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO X**	**N/A**			The provider has not served any youth meeting the criteria for FYRAC since the last QI review.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating			**X**				
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office			**X**				
Intake and initial assessment sessions meets the following criteria: a. Face-to-face gathering of family history and demographic information b. Includes development of the service plan and is documented through signature of the youth and his/her			**X**				

parent/guardian as well as orientation to the program							
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Individual Sessions are with the youth and family and focus to engage, identify strengths and needs of each member that help to improve family functioning			**X**				
Group Sessions: a. Focus on the same issues as individual/family sessions with the overall goal of strengthening relationships and prevention domestic violence b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session			**X**				
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff			**X**				
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						**YES X NO (explain)** The agency has a policy in place titled 2.10 Stop Now and Plan (SNAP) that addresses the requirements of the indicator. The policy was last reviewed on January 6, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Quality Improvement Review

Lutheran Services Florida/Southwest – Oasis – March 10 – 11, 2021
Lead Reviewer: Ashley Davies

SNAP Clinical Groups							
Youth are screened to determine eligibility of services	**X**					There were four files reviewed, two open and two closed. All four files had the NetMIS Screening form and SNAP Brief Intake Screening form.	
Needs assessment is completed at initial intake, or within two face-to-face sessions	**X**					Needs Assessment was initiated at intake in all four files.	
SNAP Assessments a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post) b. Teacher Report Form (TRF) completed by the teacher (pre & post) c. Tool for Parenting Self Efficacy (TOPSE) completed by the caregiver (pre & post) d. Prevention Assessment Tool (PAT) (pre & post)	**X**					A pre CBCL was completed in all four files. A post CBCL was completed in both of the closed files. A pre TRF was sent to the teacher to complete in all four files. A completed TRF was returned in two of the files. The remaining two files documented a follow-up email with the teacher in attempts to get the form completed. A post TRF was emailed to the teacher to complete in the two closed files. In one of the files the teacher returned the form completed. The other file contained documentation of emails sent to the teacher in attempts to get the form competed; however, the teacher never returned the form. A pre TOPSE was completed in all four files. A post TOPSE was completed in the two closed files. A pre PAT was completed in all four files. A post PAT was completed in both closed files.	
SNAP discharge report summary	**X**					Both closed files had a SNAP discharge report summary.	
SNAP Boys/SNAP Girls **Parent** Group Evaluation Form	**X**					Both closed files had a Parent Group Evaluation Form.	
SNAP Boys/SNAP Girls **Child** Group Evaluation Form	**X**					Both closed files had a Child Group Evaluation Form.	
SNAP in Schools							
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Weekly attendance sheet with youth names and/or identifying number completed with signatures of teacher and facilitator(s) (For a total of 13 attendance sheets)	**X**					All 13 weekly attendance sheets were present with youth names and teacher and facilitator signatures.	

Quality Improvement Review

Lutheran Services Florida/Southwest – Oasis – March 10 – 11, 2021
Lead Reviewer: Ashley Davies

"Class Goal" sheet	**X**					"Class Shoot for Your Goal" sheet was completed.	
Measure of Classroom Environment (MoCE) (Pre and Post) is used to identify baseline and treatment outcomes of reported classroom dynamics.	**X**					There was a pre and post MoCE completed.	
Pre and Post Evaluations	**X**					Pre and post evaluations were present for all youth and the teacher.	
One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox	**X**					There was one Fidelity Adherence Checklist completed during the 13-week group and the program reported to was uploaded to Dropbox.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES X NO (explain)** The agency has a policy in place titled 3.01 Shelter Environment that addresses the requirements of the indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Facility Inspection	**X**					A virtual tour of the facility revealed furnishings were in good repair. The program was free of insect infestation. Grounds were landscaped and maintained. Bathrooms were clean and functional. No graffiti was observed. Lighting was adequate. Exterior areas were free of debris and grounds were free of hazards. Dumpster and garbage cans were covered. Doors were secured with key access required. Egress plans were posted in several locations. The client rules, abuse hotline information, and DJJ incident reporting information was posted on a bulletin board in the dayroom. Blank grievance forms were available located next to the locked grievance box in the dayroom. The program has two vans used for transporting youth which were equipped with major safety equipment as required. Interior areas of the vans did not contain contraband and were free of hazardous items. Chemicals were stored behind locks and inventories and MSDS were maintained. The washers and dryers were operational and clean of lint. A current DCF license was displayed. Each youth has their own individual bed with clean, covered mattress, pillow, and sufficient linens. The program has a locked cabinet that serves as a safe place for youth to keep their personal belongings.	
Fire and Safety Health Hazards	**X**					The annual fire inspection was completed on January 15, 2021. The annual fire sprinkler inspection was September 18, 2020 and the quarterly inspection was December 18, 2020. The annual fire extinguisher inspection was February 5, 2021. The annual fire alarm inspection was August 4, 2020. A review of drills indicated the program conducted on average three fire drills per month. The program also completed mock emergency drills, including at a minimum, one per shift per quarter. Residential Group Care and Food Service inspection was completed on November 10, 2020. The kitchen exhaust inspection was March 9, 2021. Menus were posted and signed by a licensed dietician. Cold food was properly stored, marked, and labeled, and dry storage/pantry areas were clean. Refrigerators/freezers were clean, and temperatures were maintained.	

Quality Improvement Review

Lutheran Services Florida/Southwest – Oasis – March 10 – 11, 2021
Lead Reviewer: Ashley Davies

Youth Engagement							
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**X**					The daily schedule reveals that youth are engaged in meaningful, structured activities seven days a week. The schedule also provides for at least one hour of physical activity. Youth are given the opportunity to participate in faith-based activities with non-punitive activities offered for those who choose not to participate in those activities. Youth are given the time and opportunity to do homework and read. The program has a library with a variety of books for the youth to read. The schedule was observed posted on the bulletin board in the dayroom during the virtual tour.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						**YES X NO (explain)** The agency has a policy in place titled 3.02 Program Orientation that addresses the requirements of the indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth received a comprehensive orientation and handbook provided within 24 hours	**X**					There were five shelter files reviewed, one open and four closed. An orientation checklist was observed in all five files reviewed and completed on the day of admission. All five files documented the youth	

						received a handbook. The youth and parent signed the acknowledgment page in each file.	
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**X**					The orientation checklist was completed in all five files reviewed and documented all required topics were covered.	
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	**X**					The Youth Orientation Checklist was completed in all five files reviewed and signed and dated by the youth and staff.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						**YES X NO (explain)** The agency has a policy in place titled 3.03 Youth Room Assignment that addresses the requirements of the indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Quality Improvement Review

Lutheran Services Florida/Southwest – Oasis – March 10 – 11, 2021
Lead Reviewer: Ashley Davies

A process is in place that includes an initial classification of the youths, to include:							
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Sexual orientation gender identity/ expression k. Acute health symptoms requiring quarantine or isolation	**X**					There were five shelter files reviewed, one open and four closed. The program utilizes the Youth Intake Form to document the initial classification process and room assignment. All five files included this form completed in its entirety and signed by a staff member and supervisor. This form documented all required elements.	
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	**X**					Four of the five files documented the youth had alerts. All four files documented the alert was entered into the program's alert system by placing the applicable color-coded dot on the youth's file and completing the Alert Checklist form locate in the files.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						**YES X NO (explain)** The agency has a policy in place titled 3.04 Log Book Requirements that addresses the requirements of the indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Quality Improvement Review

Lutheran Services Florida/Southwest – Oasis – March 10 – 11, 2021
Lead Reviewer: Ashley Davies

Log book entries that could impact the security and safety of the youth and/or program are highlighted	**X**					Logbook entries were reviewed for September 1-7, 2020, October 7-14, 2020, November 14-21, 2020, December 21-28, 2020, January 1-7, 2021, and February 7-14, 2021. The program utilizes the NoteActive electronic log book. Entries that impacted the safety and security of the youth or program were observed highlighted.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	**X**					All entries were brief and legible, included the date and time of the event, included names of youth and staff involved, provided a brief statement, and included the name and signature of the person making the entry.	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**X**					Errors were observed struck through with a single line and initialed.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	**X**					The program director designee reviewed the logbook every week and made a note chronologically with recommendations, dates reviewed, and signed the entry.	
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed		**X**				There was some documentation staff were reviewing the logbook each.	**Exceptions:** All staff were not consistently reviewing the log book each shift and making an entry stating they reviewed the previous two shifts

							with the dates reviewed. There were eleven instances observed in the log book entries reviewed where all staff on shift did not document this review.
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	**X**					The on-coming supervisor and shelter counselor would document reviews of the logbook with dates reviewed and make a signed entry.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**X**					Entries were observed for counts, visitation, and home visits.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						**YES X NO (explain)** The agency has a policy in place titled 3.05 Behavior Management Strategies that addresses the requirements of the indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program has a detailed written description of the BMS, and it is explained during program orientation	**X**					The program has a written description of the behavior management system that is given to the youth at intake. This was confirmed in all five shelter files reviewed.	
Behavior Management Strategies MUST include: a. Supervisors are trained BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions	**X**					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 behavior management system	

b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges						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 to consider alternate behaviors. Consequences are applied logically and consistently. Youth are never denied food, clothing, rest, services, contact or exercise.	
Program's Use of the BMS							
All staff are trained in the theory and practice of	**X**					All staff are trained regarding the behavior management system at the time of hire. A review of	

administering BMS rewards and consequences						ten staff training files confirmed all staff were trained on the program's behavior management system.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**X**					All staff receive supervision regarding their implementation of the system both individually and during staff meetings.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**X**					The supervisors are trained to monitor the use of interventions by their staff during monthly staff meetings.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES X NO (explain)** The agency has a policy in place titled 3.06 Staffing and Youth Supervision that addresses the requirements of the indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	**X**					There were four random samples of video surveillance reviewed, February 18, 2021 from 12am - 1am, February 27, 2021 from 5am - 6am, March 4, 2021 from 3am - 4am, and March 9, 2021 from 1am - 2am. A review of the above video surveillance sample, staff schedules, and log book entries documented required staffing ratios were met for awake hours and sleeping hours.	
All shifts must always provide a minimum of two staff present	**X**					The random sample above, log book entries, and staff schedules reviewed for the last six months documented at least two staff were present on all shifts.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	**X**					All staff that were included in staff-to-youth ratios had an eligible background screening completed and had been appropriately trained.	

The staff schedule is provided to staff or posted in a place visible to staff	X					During the virtual tour, the schedule was observed posted in the Youth Care Specialist (YCS) office area.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	X					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 observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	X					A review of the video surveillance system for the four random samples listed above showed consistent fifteen-minute checks by staff. The log book also confirmed staff were constantly observing the youth every fifteen minutes and documenting observations in real time.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						**YES X NO (explain)** The agency has a policy in place titled 3.07 Video Surveillance that addresses the requirements of the indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Surveillance System							
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability	X					Observed cameras and written notices during the virtual tour. System can capture and retain video images for up to thirty days. A review of random samples of overnight video surveillance revealed system records date, time, and location, and enables facial recognition. Cameras have back-up capabilities in case of power outage. All cameras were visible, and no cameras were located in the bathrooms or sleeping rooms.	

to operate during a power outage e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible							
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**X**					The programs maintains a list of staff who can access the video surveillance system. The list consisted of supervisory staff.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook. The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**X**					Supervisory reviews were conducted at least every 14 days for the last 6 months and documented in the log book. The reviews included a random sample of overnight shifts and assessed the activities of the facility and included any corrections needed.	
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	**X**					The program has procedures in place in policy 3.07 Video Surveillance to handle requests of video recordings within 24 – 72 hours.	
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	**X**					The program has procedures in place in policy 3.07 Video Surveillance System to ensure service orders are made within 24 hours of discovery and includes documentation requirements.	

Quality Improvement Review

Lutheran Services Florida/Southwest – Oasis – March 10 – 11, 2021
Lead Reviewer: Ashley Davies

Provider has a written policy and procedure that meets the requirement for Indicator 4.01						**YES X NO (explain)** The agency has a policy in place titled 4.01 Healthcare Admission Screening that addresses the requirements of the indicator. The policy was last reviewed on January 6, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Preliminary Healthcare Screening							
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	**X**					There were five shelter files reviewed, one open and four closed. The health screening section of the CINS/FINS Intake Form was completed in all five files and included all required elements. The program had implemented procedures to take the youths temperatures at intake and screen youth for COVID-19 related symptoms. All health screenings were reviewed by a Registered Nurse (RN) within five business days.	
Referral and Follow-up							
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)			**X**			None of the five youth presented with chronic conditions requiring a referral to ensure medical care.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments			**X**			None of the youth required follow-up medical appointments.	
All medical referrals are documented on a daily log.			**X**			None of the five youth required any type of medical referrals.	
The program has a thorough referral process and a mechanism for necessary follow-	**X**					There are procedures in place to involve the parent in any follow-up medical care or referrals needed.	

up medical care as required and/or needed							
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						**YES X NO (explain)** The agency has a policy in place titled 4.02 Suicide Assessment that addresses the requirements of the indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Suicide Risk Screening and Approval							
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**X**					There were five shelter files reviewed, one open and four closed. All five files contained a suicide risk screening completed during the initial intake screening process that was signed by a supervisor.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**X**					The program's suicide risk assessment tool was reviewed, and it was reported it had been previously approved by the Florida Network.	
Supervision of Youth with Suicide Risk							
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**X**					Three out of the five youth were placed on sight-and-sound supervision until assessed by a mental health professional. A suicide risk assessment was completed by a licensed professional or non-licensed professional under the direct supervision of the licensed professional within 24 hours in all three files. The three youth were appropriately removed from suicide precautions.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**X**					In all three files the observation logs documented the youth were monitored at least every thirty minutes while on sight-and-sound supervision.	
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further	**X**					All three youth were removed from sight-and-sound supervision after a suicide risk assessment was completed by or reviewed with the licensed professional.	

assessment OR Baker Act by local law enforcement							
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES X NO (explain)** The agency has a policy in place titled 4.03 Medication that addresses the requirements of the indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Medication Storage							
a. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Med-Station	**X**					A virtual tour of the Pyxis Med-Station was completed. The Pyxis Med-Station is located in the medication room and is inaccessible to youth. All medications are stored in the Pyxis Med-Station 4000 medication cabinet. Oral medications are stored separately from topical medications in the locked medical cabinet. There is a secure refrigerator used only for medical purposes and maintained at 36 degrees F. The temperature of the refrigerator is checked weekly by the RN. All narcotic and controlled medications are stored in the Pyxis Med-Station 4000 medication cabinet.	
Medication Distribution							
a. Agency maintains a minimum of 2 Super Users for the Med-Station b. Only designated staff delineated in User	**X**					A list of Super Users was provided, and a list of designated staff delineated to have access to secured medication. The program has two Super Users for the Med-Station, the RN and the Residential	

Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse						Services Manager. A review of three youth files supported they took medication while in the program. All three files contained a Medication Distribution Log (MDL) completed as required. Staff verify medication either by the Registered Nurse (RN) or by calling the pharmacy. The RN distributes all medications when on-site. Trained direct care staff distribute medication when the RN is not on-site. All medication in the three files reviewed was distributed as required. All staff have training in the use of epi-pens by the RN. This was confirmed in the ten staff training files reviewed.	
Medication Inventory							
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory	**X**					All controlled substances are counted shift-to-shift with two staff members present and documented on the youth's MDL. A perpetual inventory with running balances is also maintained on the MDL's for all medications. All medications stored in the Med-Station, including all over-the-counter (OTC) medications, are inventoried weekly by the RN. Razors are secured in a locked file cabinet and are inventoried weekly and as used.	

c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly							
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	**X**					The RN runs weekly and monthly reports via the knowledge portal.	
Medication discrepancies are cleared after each shift.	**X**					At the time of the review there were no open discrepancies. The RN reported all discrepancies are cleared out at the end of shift. The RN also runs a weekly discrepancy report via the Knowledge Portal. Staff are aware that discrepancies should be cleared at the end of each shift.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						**YES X NO (explain)** The agency has a policy in place titled 4.04 Medical/Mental Health Alert Process that addresses the requirements of the indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**X**					There were five shelter files reviewed, one open and four closed. Four of the five files documented the youth had alerts had were placed in the program's alert system.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**X**					In the four applicable files reviewed precautions concerning prescribed medications and medical/mental health conditions were documented on intake and screening forms and on the youth's MDL's.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**X**					All ten staff training files reviewed confirmed staff are provided training on emergency medical care. Staff are also provided information and instructions on how to respond to each individual youth's medical/mental health problems on that youth's screening forms, assessments, and MDL's.	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods	**X**					Alerts are documented on all intake and screening forms in the youth's file and then the applicable color-coded dot is placed on the youth's file. The alerts are then documented on the alert board located in the YCS office. All files also contain an alert checklist. Any dietary alerts are located on a form in the kitchen. The	

and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff						alert system includes precautions concerning prescribed medications and medical/mental health conditions. Staff can find this information documented in the youth's file and on the youth's individual MDL's.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						**YES X NO (explain)** The agency has a policy in place titled 4.05 Episodic/Emergency Care that addresses the requirements of the indicator. The policy was last reviewed on January 12, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Off-site Emergency Services							
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided		**X**				There were two closed shelter files reviewed for off-site emergency medical care. Both incidents had an incident report completed. Neither youth had any type of follow-up required. In both cases the youth's parent was notified and transported the youth to the hospital. Both incidents were documented in the NoteActive electronic log book.	**Exception:** Neither incident was documented on the program's Episodic Care Log and only one of the two incidents was reported to the CCC.
All staff are trained on emergency medical procedures	**X**					There were ten staff training files reviewed. All ten staff had current First Aid and CPR certifications.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**X**					The shelter has two sets of knife-for-life and wire cutters. One set is located on the wall in the laundry room. The second set is located in the staff office.	
First aid kit/supplies are fully equipped and inventoried	**X**					There are first aid kits located in the nurse's office and dayroom. Shelter staff review the kits on a weekly basis to ensure they are well stocked.	