Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Arnette House
Residential Program

December 10-11, 2018

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity, Gender Expression	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 Special Populations	Satisfactory
3.08 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: 100.00%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%

Rating Definitions

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

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.
Not Applicable	Does not apply.

Reviewer

Members

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

Warren Garrison, Regional Monitor, Department of Juvenile Justice

Tracy Bryant, Business Analyst II, Hillsborough County Children's Shelter

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Quality Improvement Review
Arnette House – December 10 – 11, 2018
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 2018).

Persons Interviewed

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

Documents Reviewed

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

Surveys

- **7** # Youth
- 2 # Direct Care Staff
- **0** # Other: _____

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

The Arnette House organization is a non-profit children and families service organization located in Ocala, Florida. The agency is currently engaged as a local service provider agency with the Florida Network of Youth and Family Services to provide Children In Need of Services (CINS) and Families In Need of Services (FINS) in the North Central area of Florida. The agency is led by a Chief Executive Officer and a Chief Compliance Officer, Chief Financial Officer, Licensed Clinical Mental Health Counselors, and more than twenty residential staff members. The residential shelter is licensed by the Department of Children and Families to serve twenty residents at one time.

Since the last QI review, Arnette House has hired a new Clinical Supervisor, a new Family Counselor, and a new Intake Coordinator. The agency has received funding to have a pool built on property, it will be called the Sara Arnette Aquatic Center. The SNAP program has started, and they are looking for more youth, so far there are fifteen total youth between boys and girls. The Boys and Girls Club wants to partner with the SNAP program to run groups at the Club. The agency received United Funding to fund two more counselors. These counselors will be going into schools to conduct groups.

Standard 1: Management Accountability

Overview

The program's senior management team includes the executive director, chief financial officer, human resource officer, clinical supervisor, shelter program manager, and assistant shelter manager. Management and committee meetings are conducted to address shelter operations, program planning, incidents, corrective action, personnel processes, and other information as needed. All-staff meetings are conducted to share information from the management and committee meetings with staff. The human resource officer is responsible for background screening of new employees and re-screening of employees every five years. The human resource officer ensures new hires receive and acknowledge personnel and program expectations. The human resource officer also oversees staff training. The program has several interagency agreements with various community partners, to include law enforcement, education, healthcare, and service provider agencies. Representatives from the program regularly participate in meetings with multiple community entities.

1.01 Background Screening of Employees/Volunteers

☒Satisfactory ☐ Limited ☐Failed

The program policy on background screening is in accordance with Chapter 435, 984,985,943 Florida Statutes, and The Department's statewide procedure (FDJJ-1800). The policy was last revised on May 29, 2018 and reviewed on December 10, 2018 by the CEO.

The Human Resource Officer or designee will submit the Request for Live Scan Screening form, a fingerprint card and copies of the individual's driver's license and social security card to the Department of Juvenile Justice as required for the background screening process. No employee, volunteer, intern or independent contractor may be hired or utilized at the Arnette House prior to the successful completion of the background screening.

In addition to the Department of Juvenile Justice background screening procedure, the Arnette House conducts an E-Verify check to verify employment eligibility and checks it against data from Federal government databases to verify an employee's employment eligibility status. A local criminal history background check along with employment and personal reference checks are conducted also.

A motor vehicle report will be obtained on each candidate tor employment. In the event an applicant is uninsurable, they will be ineligible for hire in any position that requires

continuous contact/direct care of clients. If at any time after the initial hiring, an employee is deemed uninsurable by the agency or insurance carrier, the event will be reviewed on a case by case basis, and the employee may be terminated. A review of employee insurability will be conducted annually.

All applicants and volunteer/interns/independent contractors, shall complete a notarized Affidavit of Good Moral Character. This document becomes a part of the individual's personnel file and any falsification of information on this document will be cause for a decision not to hire and/or termination if discovered after employment has begun.

Re-screening: The Human Resource Officer or designee will re-screen all employees every five years in accordance with the Department of Juvenile Justice policy. Local criminal history background checks will also be conducted every five years.

Annual Affidavit of Compliance with Good Moral Standards is completed and notarized at the end of calendar year to document that all staff met the standards. The report is submitted to the Inspector general of the Department of Juvenile Justice by January 31.

The program completed the Annual Affidavit of Compliance with Level 2 Screening Standards during the current calendar year. The affidavit was signed by the CEO and witnessed by a notary public of the State of Florida on January 10, 2018.

Seven staff were applicable for new hire background screening. All seven staff files contained an eligible background screening completed prior to hire.

Eleven staff were eligible for five-year re-screenings. All eleven staff files contained an eligible rescreening within the applicable time frame.

Exceptions:

No exceptions are noted for this indicator.

1.02 Provision of an Abuse Free Environment

☒Satisfactory ☐ Limited ☐Failed

According to the program policy, each staff and volunteer are obligated under law (Florida Statute 984) to report any known or suspected case of child abuse or neglect immediately. The policy was last revised on May 29, 2018 and reviewed on December 10, 2018 by the CEO.

All staff sign acknowledgement of the staff handbook which contains the code of conduct, and a copy of the discipline, control and punishment policy. The program has a grievance policy which includes three steps, immediate resolution attempt, staff assigned attempt to resolve the grievance, and supervisory appeal phase. Each phase

had time limits and a process includes youth will sign the form acknowledging a written response was received from the program. The program has three business days to resolve each grievance.

During the tour of the facility, the team observed the Florida Abuse Hotline posted in prominent areas of the shelter, school, and administration buildings. There is a locked grievance box in the common/dining room for which the shelter manager holds the key and removes all grievances daily. A review of the area revealed blank grievances were stored adjacent to the box. Staff opened the grievance box revealing it was empty. The program maintains a binder with all the grievances for the past twelve months; there were no grievances filed by a youth in the last twelve months.

Each staff personnel file contained a copy of the signed acknowledgement of receipt of the employee handbook, and a signed copy of receipt of policy 65-C14.021 Discipline, control and punishment. There was no documentation found of allegations towards staff of abuse, neglect or harassment in the review period. Staff interviews confirmed there were no instances in which staff had been accused of or disciplined with verbal reprimand, written warning, suspension, or staff dismissal for violations of the code of conduct in the review period.

There were seven youth surveyed. Four of the seven youth reported they knew the Abuse Hotline was available for them to call if they wanted, however, all seven stated they have never needed to make a call. All seven youth stated staff treat them professionally and they have never heard staff use threats or intimidation on them or any other youth. All seven youth felt safe in the shelter.

There were two staff surveyed. Both staff reported they have been trained on abuse reporting and both reported they were aware they needed to report any suspected abuse to the Abuse Hotline. Both staff reported they have never heard a staff deny a youth access to the abuse hotline. Both staff reported they have never heard another staff use inappropriate language in front of the youth.

Exceptions:

No exceptions are noted for this indicator.

1.03 Incident Reporting

☒Satisfactory ☐ Limited ☐Failed

The program has a policy addressing incident reporting concerning safety and liability issues, including cases of incidents in vehicles and/or off campus, to assure prompt

attention by case managers, counselors, and administration. The policy was last revised on May 29, 2018 and reviewed on December 10, 2018 by the CEO.

An Incident Report Form will be completed by the Arnette House staff member having the most immediate or thorough knowledge of an occurrence involving property, a client or a staff member. If the youth is a resident and Department of Children and Families (DCF) is the guardian, a DCF incident report will also be completed and faxed to the DCF contract manager. The following circumstances constitute the need for completion of the form: emergency situations, life threatening situations, incidents involving clients or staff members which may be considered unusual or a threat to safety, and may have residual effects, runaways, and any other occurrences as specified in program policy and procedures.

If a client is involved, the Team Leader must be notified immediately. The Team Leader will report necessary incidents to the Shelter Program Manager and fill out an Incident Report as directed. When describing the incident, be as accurate and detailed as possible. The report must include all facts and circumstances involved and identification of all parties involved. Include any actions taken, especially notifications of Law Enforcement, Emergency Medical Technicians (EMTs), Parents and/or DCF or Department of Juvenile Justice workers. If Law Enforcement is notified be sure to include Officer's name, Identification number, case number and action taken by officer, including arrest, filing a missing person's report, or intervention.

The Incident Report Form will be filled out completely and submitted to the Shelter Program Manager within twenty-four hours of the incident or the next business day for review. If no further follow-up is required, the report is then forwarded to the Chief Executive Officer (CEO) for final approval. Once the report is approved by both the Shelter Program Manager and the CEO, it will be copied and the original will be placed in the residents file, and a copy is maintained in the Intake Coordinators office. The Incident Reports will be tallied according to incident and filed according to category by the tenth of the following month.

Incident reportable to the Department Central Communications Center (CCC): The on-call Counselor and/or Team Leader will determine whether immediate notification of the CCC is required. Type "A" & "B" incidents that are reportable to the CCC and must be reported within 2 hours.

All incident reports will be reviewed by the Clinical Committee once a month for appropriate documentation and to look for trends within the departments. The recommendation from the Clinical Committee is than submitted to the Program Quality Improvement (PQI) committee for approval and implementation of the recommendations.

All six incidents reported to the CCC were found documented in the logbook. The program had six incidents which met the requirements for notification to the CCC during the review period. Each of the incidents were reported within the two-hour time frame. There was documentation in the incident binder for the six incidents. Each of the six were documented on an incident reporting form. Each report form documented the persons notified including date and time of the incident and initials of the person making notification. Documentation for all incidents included a review by the compliance officer and the CEO.

Exceptions:

No exceptions are noted for this indicator.

1.04 Training Requirements

☒Satisfactory ☐ Limited ☐Failed

The program has three policies regarding training: Orientation, Training and Staff Development, and Mandatory Training. The policies were last revised on May 29, 2018 and reviewed on December 10, 2018 by the CEO.

Mandatory Training:

In an effort to develop and maintain a well-trained staff, and to comply with Department requirements, Arnette House has determined it is necessary for all employees to attend certain mandatory training sessions annually. Annual mandatory training required includes but is not limited to: CPR, First Aid, Fire Safety, Crisis Intervention, Suicide Prevention and human immunodeficiency virus (HIV) Disease Prevention. In addition, Children in Need of Services (CINS) Core training is required in the first year of employment. Some mandatory training is determined by the department in which staff is employed.

Employees who are delinquent in training hours as of July 1 of each year, will not be considered for any potential salary increases. It is the employee's responsibility to make any necessary arrangements to ensure training standards are being met.

Orientation, Training and Staff Development:

Arnette House provides orientation and training for all employees. The training may be in-service or outside Arnette House conducted by professional trainers. All full-time personnel are required to obtain a minimum of eighty hours of training in the first year of employment and forty hours of training each year thereafter. Part time employees are required to obtain twenty hours of training annually. Supervisors are required to complete forty hours training annually, twelve of which is to be supervisory training. (See Mandatory Training Policy for additional information). Orientation is completed in

accordance with outlines specific to the employee's department within sixty days from the date of hire. Orientation includes but is not limited to such topics as: the Arnette House mission, goals and objectives, policies and procedures, organizational structure, continuum of services, characteristics of our clients, judicial and regulatory issues, crisis intervention, suicide prevention, our Community Partners, and Quality Improvement Initiatives. In the shelter residential program, job shadowing is also included in the orientation process.

The nature of Arnette House's operation necessitates the mandatory attendance of designated staff members at scheduled staff development meetings. The function of the meetings is to discuss clinical and/or programmatic issues in an open forum, training, and to receive status reports from each department. An employee may be excused from attending a scheduled staff development meeting only upon receiving the prior permission from his/her supervisor or in the event of an emergency. Repeated unexcused absences from staff meetings will result in disciplinary action up to and including termination.

Staff must complete mandatory training requirements within time frames required by contractual, Quality Assurance, and Council on Accreditation (COA) standards in order to maintain good standing for employment. Employees not meeting these requirements will not be permitted to work scheduled shifts until the training requirements have been met. Training requiring certification must be kept current. If employee is unable to attend the training provided by the Arnette House, they must obtain their certification at another approved location at their expense.

The program maintains physical training records as well as a digital training record. The physical training records contains certificates of completion, and annualized totals of completed training. The digital records were accessible to supervisory and administrative staff for oversight and quality assurance. The program includes the steps for staff to take to complete training on each individual staff training plan. Staff interviews revealed program staff provide the required instructor-led training and staff complete additional and mandatory training on both the program’s web-based module and the Department’s Learning and Management System (SkillPro).

There were three staff training records were reviewed for compliance with training in the first 120 days and first year of employment. Two of the three new-hire staff had completed one year, both had an excess of eighty hours of training with 88.5 and 100.5 hours. All required trainings had been completed. The third staff had only been with the agency for two weeks at the time of the review. This staff had documented forty-eight hours of training so far. Many required trainings during the first 120 days had been completed. This staff was on track to exceed the required eighty hours of first year training, as well as to receive all required trainings.

There were four staff training files reviewed for in-service training requirements. All four staff received the more than the required forty hours of in-service training. Two staff documented all required trainings were completed and two staff were missing training in Fire Safety, which is to be completed every two years.

Exceptions:

No exceptions are noted for this indicator.

1.05 Analyzing and Reporting Information

☒Satisfactory ☐ Limited ☐Failed

The agency has a policy in place titled Analyzing and Reporting Information. The policy was last revised on May 29, 2018 and reviewed on December 10, 2018 by the CEO.

The program has procedures in place that each department will collect quality measurements throughout the month and will submit the to the quality improvement specialist before the 5th of the following month. The supervisor or designee submits the records to the clinical supervisor to meet with the clinical committee to be reviewed. Any trends or antecedents noticed during the review will be reflected in the data. The data will be presented by the clinical supervisor to the PQI committee to review as well. any recommendations will be presented by the department representatives for improvements for best practice and to establish needs for additional training for staff.

Each month the program's supervisor collects data and monthly reports to analyze and send them to the quality improvement specialist to be reviewed by the PQI. Once the committee on the PQI reviews all the data they make recommendations back to the program to implement new procedures or practices. This writer reviewed both residential and non-residential quarterly file reviews for the current quarter. Many sample files were reviewed, notes were made on the reviews if needed, and they were all signed by the reviewer.

The program provided their quarterly review of incidents, accidents and grievances. Notes and minutes from the PQI committee were provided for the current quarterly review. The agenda shows the committee discussed the following: implementation of quality improvement plan, review of the sub-committee's reports, corrective action plans (external audits, licensing, contract monitoring, and any reviews), review developed and revised plans, review and final approval for new forms, future trainings for staff, review client grievances and possible corrective actions needed, and the monthly benchmarks.

The program provided clinical sub-committee meeting agendas, with the sign-in sheet, that shows they discussed the following: youth charts, incident reports from the programs, monthly benchmarks for both residential and non-residential departments, and any major concerns in the departments. The program provided their review of customer satisfaction surveys for both residential and non-residential departments. The program provided documentation, signed by those in attendance, of the monthly review of NetMIS data reports and their annual review of outcome data. Data is pulled that both

identifies the program's strengths and areas for improvement, along with ways to improve and implement new procedures and practices. Once the information is finalized, the program supervisor will relay the information to staff through the log book, memos and in meetings. The program's nurse pulls reports from CareFusion 3 times a month for the following reports: Critical Lows, Pockets Inventoried, and Discrepancy Audit Summary. These reports are dated by when they are generated.

Exceptions:

No exceptions are noted for this indicator.

1.06 Client Transportation

☒Satisfactory ☐ Limited ☐Failed

The agency has a policy and procedure in place titled Client Transportation. The policy was last revised on May 29, 2018 and reviewed on December 10, 2018 by the CEO.

Before a youth can be transported to any non-medical appointment or service by the shelter, the following information must be obtained: All drivers must be approved by the Administration to drive youth in Agency vehicles covered under the Agency's company insurance policy; if at any time a drivers driving privileges have been suspended or revoked that information will be given to that driver's supervisor and documented immediately; to transport, staff must have permission from the Shelter Program Manager or designee or team leader; no more than five residents will be under the supervision of one staff member. This applies to youth and staff on a trip and those remaining at the shelter. Collateral agency staff (volunteers, tutors) may assist in supervising youth in order to preserve ratio; per DCF contract, a 1:5 ratio will be maintained at all times when transporting youth in the Agency vehicle; all trips must be documented in the logbook with departure time, staff and youth involved, destination and expected return time; staff shall not transport residents in personal vehicles.

Single transports: the best practice would be not to transport a youth by yourself in a vehicle. However, if a 3rd party cannot be obtained for transport, the youth's history, evaluation, and resent behavior must be considered before the transport, the youth's history, evaluation, and resent behavior must be considered before the transport. If a driver is transporting a single youth in a vehicle, there must be evidence that the Program Supervisor or his/her designee is aware (prior to the transport) and consent is documented in the logbook and the vehicle logbook.

The agency has a form that is kept in the van logbook. Whenever there is a single transport the shelter Program Manager will document on the form the time of approval and whether the youth is a CINS or DCF youth. This information is also documented in the electronic logbook. This information was found documented for all single client transports.

The van log was reviewed for all client transports. The log included the date, beginning and end time and odometer, number of passengers, gas level, supervisory approval, time of approval and category of trip (Department of Children and Families/Department of Juvenile Justice). This log was found to be consistently filled out for each transport.

Exceptions:

No exceptions are noted for this indicator.

1.07 Outreach Services

☒Satisfactory ☐ Limited ☐Failed

The agency has a policy in place titled Outreach Services. The policy was last revised on May 29, 2018 and reviewed on December 10, 2018 by the CEO.

Arnette House will contribute to the implementation of Departmental objectives through participation in local and circuit level meetings the assigned representatives to these groups will advocate for the effective use of CINS/FINS Services and update agency leadership on meeting activities. Arnette House will provide minutes to meetings; provide verification of attendance at DJJ Board and Council meetings; and provide support and accommodation for representative to participate in assigned meetings. The agency also maintains written agreements with other community partners that include services provided and a comprehensive referral process.

Arnette House is very active in the community. Staff participate in the Circuit 5 Review Team, DJJ Circuit 5 Advisory Board, Lake County Human Trafficking, Lake County Review Team, and Detention Advisory board. The agency keeps minutes and sign in sheets of meetings attended. Reviewed meetings from June 2018 to December 2018.

The agency maintains a logbook of Interagency Agreements with various organizations such as National Safe Place, Silver River Mentoring & Instruction, Department of Education, school board, American Red Cross, United Way, Ocala Police Department, Sheriff of Marion County, health department, and Children's Home Society.

The program documented meetings with various community agencies and attendance at activities or functions related to youth services. The program has developed a pamphlet and cards that include contact information and a description of service delivery. The pamphlets and cards are available in and throughout the community. The program is a member of the National Safe Place Network.

Exceptions: No exceptions are noted for this indicator.

Standard 2: Intervention and Case Management

Overview

Arnette House is a contracted CINS/FINS agency that provides both residential and non-residential services for youth and families in Marion and Lake Counties. This agency has a centralized intake and screening process that is available seven days a week, 24 hours a day to the community. Referrals for services come from a variety of sources including the school system, law enforcement, parents, and the Case Staffing Committee. Non-Residential services cover Marion and Lake Counties and include individual, family, and group counseling. Non-residential counseling services are provided primarily in the school with the additional option of conducting services in the agency's office. The school system and Arnette House works closely together to support children/families in becoming successful.

The Non-Residential program is also responsible for coordinating the Case Staffing Committee (CSC) which is a mandated process within the Florida Statutes. It's primary focus is to address issues related to habitually truant, ungovernable, and/or persistent runaways. The CSC is initiated at the request of the parent/guardian, by the school system or when other less restrictive options have been exhausted. Arnette House case managers convene the CSC and track progress. If no progress is made, the CSC may recommend filing a Child in Need of Services (CINS) petition with the court. Arnette House case manager follows the youth (and family) through the course of the judicial process and tracks progress.

2.01 Screening and Intake

☒Satisfactory ☐ Limited ☐Failed

Agency has written policies and procedures in place to address the screening and intake process. Screening and Intake policy was reviewed by the CEO on 5/29/2018.

The screening policy states Arnette House screens children and families for eligibility to facilitate an appropriate match between the needs of the child and family and the organization’s services.

The procedure states screenings for service eligibility and severity of problems are conducted by trained personnel in person or by telephone 24 hours/day. Per procedure screening is completed at the time service is requested or within 7 working days of referral. Eligible clients are scheduled for intake within five working days. Clients/families that are ineligible receive referrals to other community organizations.

The intake procedure states the intake assessment is initiated within seven working days of the referral. The intake is completed during a face to face appointment and the following information is verbalized:

1. Available treatment and service options
2. The right to refuse recommended services
3. Rights and responsibilities of parent/guardian and youth
4. Possible actions occurring through involvement with CINS/FINS services.

There were nine files reviewed, five Residential (three open and two closed) and four Non-Residential (three open and one closed).

All files had a completed screening form. The referral dates are not noted in the file. The Clinical Supervisor was interviewed and explained families are contacted and scheduled within the seven-day time frame. The program maintains a separate folder only for referrals that were not able to be screened within the seven-day time limit.

Parent signature on the placement agreement form for the five Residential files reviewed indicates they were provided with a parent brochure and possible actions occurring through CINS/FINS involvement.

The four Non-Residential files did not have specific documentation that the available service options, parent/guardian brochure, and rights and responsibilities were provided to the parent in writing. The Clinical supervisor and a Counselor were interviewed, and reported it is the practice of the agency to provide this information to parents in writing at intake.

All nine files contained a form signed at intake that is attached to the Case Plan. The form indicates parents were made aware of service options. All nine files had a signed grievance procedure form.

Exceptions:

No exceptions are noted for this indicator.

2.02 Needs Assessment

☒Satisfactory ☐ Limited ☐Failed

Agency has a written policy and procedure in place to address Needs Assessments being completed within 72 hours for Residential clients or within two to three face-to-face meeting for Non-Residential clients. Policy was last reviewed by the CEO on 5/29/2018.

Agency procedure states that needs assessments are conducted by a bachelor's or a master's level counselor and signed by a supervisor. Procedure also stated that if a child is found to be a high risk for suicide, Suicide Assessment has to be reviewed or written by a licensed counselor.

There were nine files reviewed, five Residential (three open and two closed) and four Non-Residential (three open and one closed).

All nine files reviewed had a completed Needs Assessments within the required time frame, with all required signatures, including the Supervisor. All nine Needs Assessments were completed by a bachelor's or master's level counselor. None of the nine files documented the youth had an elevated risk of suicide.

Exceptions:

No exceptions are noted for this indicator.

2.03 Case/Service Plan

☒Satisfactory ☐ Limited ☐Failed

Agency has a written policy in place for Development, Implementation, and Review of the Case/Service Plan. The policy was last reviewed by the CEO on 8/23/2018.

Agency policy states that the Case Plan is to be developed with the youth, parent/guardian, and counselor within seven days of the completion of the assessment process. Procedure states parent/guardian is to sign the Case Plan, as well as revisions, a copy of the Plan is to be provided to the guardian and the client is to acknowledge acceptance or rejection of the Case Plan. Case Plan goals are to be strength based, directed and focused on the issues presented in the assessment process. The Case Plan review policy and procedures state the Plan is to be reviewed every thirty days for the first three months and every six months thereafter for Non-Residential counseling and case management cases. The Case Plan is to be reviewed every two weeks for Residential clients. The Case Plan is to be reviewed and signed by a licensed mental health professional.

There were nine files reviewed, five Residential (three open and two closed) and four Non-Residential (three open and one closed).

All nine Case Plans reviewed were developed on the same day as the Needs Assessment. The goals were individualized and prioritized and based on the Needs Assessment. The Plans included: date initiated, persons responsible, service type, frequency, and location. Seven of the nine plans documented the goals had target dates for completion. All nine Case Plans were signed by the parent, counselor, and supervisor. Seven of the nine Plans documented the youth's signature. All applicable thirty, sixty, and ninety-day reviews were completed as required.

Exceptions:

The Case Plans did not have completion dates.

2.04 Case Management and Service Delivery

☒Satisfactory ☐ Limited ☐Failed

Agency has a policy to address Case Management and Service Delivery. The policy was last revised on 5/29/2018 by the CEO.

Policy states that agency case managers coordinate services with different providers. Policy also states that case managers are responsible for completing a Needs Assessment, planning for services, and linking to services. Cases managers will also provide ongoing monitoring and advocacy for active cases. Case management services also include case staffing, filing CINS petitions, monitoring of out of home placement. Per procedure, case manager will attend court with the family and provide documentation for these court proceedings.

There were nine files reviewed, five Residential (three open and two closed) and four Non-Residential (three open and one closed).

All nine files had an assigned case manager or counselor. Out of the nine files reviewed, seven were noted to have had referrals made. Referrals were made to a variety of services including, family counseling, substance abuse counselor, and residential services. None of the Non-Residential files had any out-of-home placement to be monitored. The counselor and case manager coordinated Case Plan implementation, monitored the youths progress, and provided support to families. These services were documented in Case Notes and on Case Plan reviews.

All three closed files documented case termination notes. Two of the three closed files were applicable for 30- and 60-day follow-ups and those were all completed in the time frame. The last file was not yet applicable for a 30-day follow-up.

Exceptions:

No exceptions are noted for this indicator.

2.05 Counseling Services

☒Satisfactory ☐ Limited ☐Failed

Agency has a policy to address Counseling Services. The policy was last revised on 8/13/2018 by the CEO.

Agency policy states that shelter services include individual, family and group counseling. Policy states that groups are conducted by staff, youth, or guests. All groups will have a clear leader/facilitator that last at least 30 mins. Topics are related to educational or developmental areas, as well as informational. Case notes are placed in the file in chronological order with evidence of ongoing case reviews by the supervisor.

There were nine files reviewed, five Residential (three open and two closed) and four Non-Residential (three open and one closed).

All nine files had Case Plans that were related to the initial Needs Assessment. Youth's progress in counseling services could be found in the Case Notes and on the Case Plan reviews. Individual and family sessions were conducted as outlined on the Case Plans.

Non-Residential counseling is conducted primarily in the school through group counseling. Individual counseling is also implemented as needed. Parent involvement occurs primarily at intake and discharge.

All files documented a clinical review by a supervisor documenting a review of the file and staff performance.

Group counseling notes are documented in a folder separate from the client file. The group folder was reviewed, groups have an identified leader, are available at the shelter at least five days per week, are at least thirty minutes in length, have a clear and relevant topic and provide an opportunity for youth engagement.

Exceptions:

No exceptions are noted for this indicator.

2.06 Adjudication / Petition Process

☒Satisfactory ☐ Limited ☐Failed

The agency has a written policy for the case staffing committee (CSC) and Adjudication/Petition Process. The policy was last revised on 5/29/2018 by the CEO.

Arnette House has a policy addressing the Adjudication/Petition Process. Policy states the Case Staffing Committee meeting is scheduled to review the case of any youth or family that the program determines is in need of services or treatment, if the youth and family disagrees with the treatment, will not participate in treatment, or if the program receives a written request from the parent or guardian or any member of the committee. Policy states Case Staffing Committee is convened within seven working days of receipt of a written request. A new or revised Plan for services is provided and the family is to receive a written report of the Case Staffing recommendations within seven working days of the meeting.

A counselor was interviewed regarding the agency's practices for this standard. The counselor reported a separate binder is maintained for the Case Staffing invitations. It was reported parents are invited by mail and/or email. The Case Staffing Committee includes a Marion County Public Schools representative, A representative from Marion County Sheriff's Office, Arnette House staff including the assigned counselor/case manager and the clinical supervisor.

There was one file applicable for this indicator. The Case Staffing was initiated by the parent. The committee convened the same day as the request. The parent received a copy of the Case Staffing Committee recommendations on the same day. Case Plan was developed and signed on the same day as well.

Exceptions:

No exceptions are noted for this indicator.

2.07 Youth Records

☒Satisfactory ☐ Limited ☐Failed

Agency has a policy titled Confidentiality of Client Information. The policy was reviewed on 5/29/2018 by the CEO.

All case records are to be maintained in a neat and orderly manner. All case records are stamped “Confidential” and are maintained in a locked cabinet and or locked room which is centrally located and available to program staff. Case records are maintained under controlled access. Case records will comply with all legal requirements.

All nine files reviewed were observed to have the Arnette House confidential statement stamped on the front. All files were maintained in a locked room, in a locked file cabinet that was marked “confidential.” The shelter had an opaque container with a lock that is used to transport files. All files reviewed were maintained in a neat and orderly manner.

Exceptions:

No exceptions are noted for this indicator.

2.08 Sexual Orientation, Gender Identity, Gender Expression

☒Satisfactory ☐ Limited ☐Failed

The agency has a policy in place titled Sexual Orientation, Gender Identity, and Gender Expression (SOGIE). The policy was effective on August 13, 2018 and reviewed on December 10, 2018 by the CEO.

Youth will be addressed by their preferred name and gender pronouns. All staff, service providers, and volunteers are prohibited from engaging in any form of discrimination or harassment of the youth based upon their actual or perceived sexual orientation, gender identity, or gender expression. All staff, service providers, and volunteers who have intentional contact with youth will have knowledge of this policy. Areas in which youth reside or are served will have signage indicating the program is a safe space of all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression. Youth will be identified in the logbook and all public-facing documents by their preferred name and gender pronouns. Youth are to be assigned a room aligning with their gender identity, or the program will provide specific documentation as to why other room assignment was determined to be suitable. Youth will be provided with hygiene products, undergarments, and clothing that affirms their gender identity or gender expression.

The shelter has copies of the Zine, located in the lobby of the shelter, for all staff to review when needed. There is a process to ensure any volunteers or visitors to the shelter are informed of this policy. A copy of the policy is located in the front of the visitor sign-in log and any volunteers or visitors are required to review this policy when

signing in. There was no documentation staff had been trained on the SOGIE policy; however, interviews with direct care staff and observations of posting throughout the facility made it evident staff did have knowledge of this policy.

The shelter has signage located throughout the shelter indicating the program is a safe space for all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression. Signage includes signs of rainbows and statements in rainbow colors.

Exceptions:

There was no documentation staff had received training on the SOGIE policy.

The agency had not yet updated their intake screening form to include a gender identification screening question.

Standard 3: Shelter Care and Special Populations

Overview

The shelter is comprised of a large central building that has two separate hallways on opposite sides of the building to house female youth on one hallway and male youth on the other. The hallways are separated by a dayroom, a kitchen, and Direct Care Work Station. When not in school, the youth spend a majority of their free time in the dayroom either engaged in group activities, playing video games, watching television or completing homework assignments on the computers. Youth attend local area schools if they are not on suspension, expulsion, or suffering from an illness. There is an industrial kitchen onsite where all meals are prepared. The large day room also acts as a cafeteria where the youth eat their meals.

The supervision of the youth is maintained by the Direct Care staff with support from administration. The Direct Care Worker staff are also responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision. The shelter's direct care staff are trained to provide the following services for the youth: screening, medication administration; health, mental health and substance abuse screenings, first aid, cardio pulmonary resuscitation (CPR), and referrals. The supervisory and counseling staff members receive referrals and monitor service delivery on a consistent and on-going basis.

3.01 Screening and Intake

☒Satisfactory ☐ Limited ☐Failed

The program has a policy in place that states that they will provide a safe and secure living environment by using an extended family model. The direct care workers will supervise house management and operations as it relates to the daily activities. The youth are required to assist with daily housekeeping chores to ensure the program is maintaining a pleasant, healthy environment and as a practice of life skills and household management skills. The policy and procedures were revised 5/29/2018 by the CEO.

The program has procedures in place that they will provide rules and guidelines that are found in a normal home setting. Youth will be responsible for keeping their belongings neat and clean. Their beds will be made daily. Other household chores will be rotated among all youth on a rotating basis. There is an alarm system to assist in the assurance of a safe environment. Alarms are on each exterior door and window to alert staff if any

are opened. A camera system is in place in all public areas and outside the shelter to assist in monitoring of clients and staff during their activities.

The facility's grounds were clean and well maintained. Girls and boys bathrooms were neat and operational. The program did not appear to have any insect infestations. The outdoors had a great variety of activities for youth to engage with: rock wall climbing, basketball hoops, place to run/walk, canoeing, and adequate places to sit. There was no apparent graffiti on anything. Each room had a bed that was covered with a quilt made by a quilting group and donated to the program, along with a pillow and sheets. There was adequate lighting, none were out or not working.

The program utilizes two refrigerators and one walk-in freezer. The refrigerators were clean and neat as well as the freezer. The freezer had raw meat stored on the top shelf on top of frozen raw vegetables and other cooked foods. Interviews with the director revealed this is common practice as the chance for cross contamination is reduced due to the food arriving frozen prior to storage in the freezer. The director also noted receiving a satisfactory rating by the Health Department validated by documentation provided by the program.

The program utilizes three vehicles to transport youth. Each vehicle was equipped with a first aid kit and fire extinguisher. None of the vehicles had an airbag deflator. The next day of the review the director ensured each van had a first aid kit, fire extinguisher, flashlight, glass breaker, seat belt cutter, and an air bag deflator.

Documentation revealed fire drills were conducted once a month on each shift and mock emergency drills were conducted once each quarter on each shift.

On November 27, 2018 the program received a satisfactory fire inspection by the Ocala Fire/Rescue Department. On May 23, 2018 the program received a passing rating on the Backflow Test & Maintenance Report. On September 18, 2018 A-Line Fire Safety completed a semi-annual system inspection and DJP security System, Inc. completed an inspection and testing on September 28, 2018. The program passed each inspection. On July 12, 2018 the County Health Department completed a Food Service Inspection Report to correct violations. The County Health Department Report delineated all previous violations and noted the program corrected each violation. A Food Establishment Inspection Report was completed by the Florida Health Department on October 15, 2018, with a satisfactory rating.

Daily schedules were posted in all living areas for both the girls and boys. Structured activities included: bike riding, fun day at the shelter, skating, ice cream, and movies. Youth are given the opportunity to engage in faith-based activities.

Exceptions:

No exceptions are noted for this indicator.

3.02 Program Orientation

☒Satisfactory ☐ Limited ☐Failed

The program has a policy in place that states they will inform clients of the rules and procedures within 24 hours of admission during their client orientation. The program will provide the client with a copy of handbook and explain it orally. The policy and procedures were revised on 5/29/2018 by the CEO.

The program has procedures in place that each youth will be oriented on the required expectations, programs rules and the behavior management strategies. This is completed within 24 hours with staff and the youth by giving the youth the client handbook and going over the information orally. Both the youth and the staff will sign and date the copy of the orientation checklist and the client handbook showing that they received a copy.

A total of six Residential files were reviewed. All files reviewed demonstrated that clients received a program orientation and a handbook within 24 hours of intake. All files indicated that disciplinary actions, grievance procedures, emergency/disaster procedures, and contraband rules were explained. Additionally, a tour of the facility was conducted, room assignments made, and suicide prevention alerts made. A review of daily activities was done, and the Florida Abuse Hotline number provided. The Intake checklist had signatures of both parent and youth.

Exceptions:

No exceptions are noted for this indicator.

3.03 Room Assignment

☒Satisfactory ☐ Limited ☐Failed

The agency has a written policy and procedure titled Youth Room Assignment. It was last revised on 8/13/18 and was signed by the CEO on 12/10/18.

The program has procedures in place that staff or team-leaders will review the youth's file and intake packet to assess any perceived risks before the youth is assigned a

room. Male youth and female youth have separate hallways for their rooms, however halls may be switched based on capacity and shelter needs. The program takes into account eight separate factors when assigning rooms to a youth; the youth's physical characteristics, the youth's perceived level of maturity, any gang affiliation, the youth's current alleged offenses, the youth's prior delinquent history, the youth's level of aggression, the youth's attitude upon admission and the youth's past involvement in aggressive behavior, sexual misconduct or emotional disturbances.

A total of six Residential files were reviewed. All files reviewed demonstrated that the youth's history, status, and exposure to trauma were reviewed along with their age, gender, history of violence, and physical size were taken into account to determine room assignment. Gang affiliation, suicide risk, and history of sexually aggressive or reactive behavior were also taken into account. Of the six files reviewed, none had any indication of disability. Alerts were indicated in all of the files and all files showed initial interactions and observations were reviewed. All six youth were appropriately assigned to a room.

Exceptions:

The agency had not updated their screening form to include the youth's gender identification.

3.04 Log Books

☒Satisfactory ☐ Limited ☐Failed

The agency has a written policy and procedure titled Logbooks. It was last revised on 5/29/18 and was signed by the CEO on 12/10/18.

The provider's procedures address both paper and electronic logbooks. Both procedures require, at a minimum, documentation of emergency situations, incidents, events, drills, medication administration, placing of a youth on or off a specified form of supervision, special instructions for supervision and monitoring of youth, youth group movement, head counts, transports away from the facility, searches, security checks and bed checks, supervisory reviews of video surveillance, requests by any person to access any youth and their relationship to the youth, home visits, admissions and discharges, and information relating to absconds.

Entries that could impact the safety and security of the youth or the program are highlighted. Entries include the date and time of the entry, a brief statement providing pertinent information, names of youth and staff involved and the name and signature of

the person making the entry. Recording errors and struck through with a single line with the staff signature on the deleted entry.

The program director or designee reviews the logbook every week and makes a note of the review in the log indicating any corrections or follow-up that is required. The oncoming supervisor and shelter counselor review the log since their last review and makes an entry in the log indicating the review has occurred. Each direct care staff receive a printed information sheet, from their supervisor at the beginning of their shift. The information includes youth count, current status of clients and any other important information for awareness of unusual occurrences or problems. The supervisor indicates in the log that the information was passed on to the Direct Care worker.

The electronic logbook was reviewed for the past three months. Entries document safety and security of clients including their location and the type of activities they are engaged in. Incidents are recorded and highlighted in yellow. Because the yellow highlight is also used for other important information it is not always clear that it is an incident being reported. Recording errors are struck through and signed and dated. Shift supervisor reviews were noted daily. At shift change a briefing on the current situation is documented, as well as a shift summary by the staff leaving shift. However, there is no indication that the previous two shifts have been reviewed in the log, by the on-coming staff. Supervision and resident counts are documented throughout the day and night. Visitation and home visits are documented clearly. Documentation of weekly review of the log by the supervisor is maintained in a separate folder with recommendations for corrections and improvement.

Exceptions:

There is no documentation of review of the previous two shifts by Direct Care Staff.

3.05 Behavior Management Strategies

☒Satisfactory ☐ Limited ☐Failed

The agency has a written policy and procedure titled Behavior Management System. It was last revised on 5/29/18 and was signed by the CEO on 12/10/18.

The provider’s procedures for behavior management address client behaviors through a point system. Clients are provided with clear behavioral expectations lists that include: Bedtime to Wake-up, Morning Chores, Breakfast, School Time, Lunch, Group / Free Time, Dinner, Outdoor Activities, and Shower Time/Hygiene. Clients can earn up to two points daily for each of these categories. Peer Leaders are chosen to work with four to

five clients to help them make better choices. These Peer Leaders work with the staff to make sure all clients are on task. Natural and logical consequences are used for client behavior. Clients have full privileges unless it is determined that their behavior precludes having those privileges. Before privileges are restricted, the client is given the opportunity to explain his or her behavior. Goals are set at the evening closure meeting and then reviewed at the next meeting to determine if the client has met the goal and what can be done the next day to do so if it was not met.

Behavioral interventions used include praise and encouragement for exhibiting self-control and desirable behaviors. Physical punishment, ridicule, intimidation, verbal abuse, cruel or humiliating treatment, excessive work or exercise, and denial of food, clothing, shelter, medical care or prescribed therapeutic activities or contact with family, counselors, or legal representatives are not used. Punishment or consequences from peers and group punishment for individual behaviors are also not used.

Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention techniques and are used only when aggressive behavior endangers the safety of staff, other youth, or themselves. Only nationally recognized techniques approved the Florida Network are used. Room restriction is not used for youth who are out of control either physically or emotionally.

The staff are trained in their new hire orientation about the behavior management system used and there is a folder for them to reference back on that breaks down the system. There is a shift meeting at the end of the day that references all point sheet for each individual youth to ensure there is no favoritism or harsh consequences for a particular youth.

Exceptions:

No exceptions are noted for this indicator.

3.06 Staffing and Youth Supervision

☒Satisfactory ☐ Limited ☐Failed

The program has a policy in place that states through providing adequate staffing, the program ensures the safety and security of the staff and clients. This ensures that the program’s mission, goals and outcomes can be achieved. The policy and procedures were revised 5/29/2018 by the CEO.

The program has procedures in place that they will keep at least one male and one female direct care worker on duty at all times. The program will keep a wake ratio of 1 staff to 6 youth, and during sleep hours they will maintain 1 staff to 12 youth. The program maintains 24-hour wake supervision of the youth. The program also requires a supervisor or counselor to be on-call on a 24-hour basis. Additional staff can be activated if the residents exceed the ratio, or if the group is more volatile.

The shelter program manager or designee is responsible for the scheduling of the direct care workers and the team leaders. The schedule will be posted in the direct care worker's office on a weekly basis. There is a team leader assigned to each shift, or a counselor or supervisor are available through on-call, to ensure there is access to a supervisor at all times. The staff phone list is to be kept in the schedule book.

Staff schedules were reviewed for the past six months. The schedules documented at least one male and one female staff on each shift. The schedules ensured the appropriate staff-to-youth ratios were maintained on all shifts. The schedule has the rotation staff documented on it as well.

Direct care staff use a proprietary software named Note Active loaded on their hand-held tablets. Note Active enables direct care staff the ability to electronically record the time staff observed the youth while sleeping. The software uses Bluetooth technology to notify staff when they are in range to conduct an observation of the youth while sleeping. The Bluetooth notification is activated once staff enters the room with a hand-held electronic tablet. Five random days were selected, and observation of cameras crossed referenced with Note Active determined staff observed youth every fifteen minutes.

Exceptions:

No exceptions are noted for this indicator.

3.07 Special Populations

☒Satisfactory ☐ Limited ☐Failed

The agency has a written policy and procedure titled Special Populations. It was last revised on 8/13/18 and was signed by the CEO on 12/10/18.

The provider's procedures for Special Populations includes Staff Secure, Domestic Minor Sex Trafficking, Domestic Violence Respite, Probation Respite, Intensive Case Management, and Family/Youth Respite Aftercare Services (FYRAC). The procedures required that Staff Secure Youth meet the legal requirements of Chapter 984 F.S. and

have been formally ordered in staff secure services. Domestic Violence Respite referrals have a domestic violence charge and are screened by JAC or the screening unit. Probation Respite referrals are made through DJJ Probation for clients with adjudication withheld. Intensive Case Management referrals are received from the court or from the case staffing committee. Family/Youth Respite Aftercare Services (FYRAC) referrals are received from DJJ.

The program has not served any Staff Secure, Domestic Minor Sex Trafficking, Intensive Case Management, or FYRAC youth since the last on-site review.

There were two Domestic Violence Respite and two Probation Respite files reviewed.

Both Domestic Violence Respite files reviewed met all the requirements including: pending DV charges, case plans that focused on managing aggression, and family coping skills. In both cases, clients did not stay beyond twenty-one days.

Both Probation Respite files reviewed met all the requirements including: referrals came from DJJ Probation, neither youths stay exceeded thirty days, and counseling goals were considered and addressed.

All four files received services consistent with CINS/FINS program requirements.

Exceptions:

No exceptions are noted for this indicator.

3.08 Video Surveillance System

☒Satisfactory ☐ Limited ☐Failed

The program has a policy in place that states they will have a video surveillance system that is in operation 24 hours, 7 days a week. The purpose for the operation is to guarantee personal accountability while capturing the agency happenings to ensure the safety of all youth, staff and visitors. This is to help deter any means of misconduct and provide video evidence to any situation that involves allegations. The policy and procedures were reviewed 5/29/2018 by the CEO.

The program has procedures in place that they will have a system that can capture the video images and will be stored for a minimum of 30 days. The system will record the date, time and location. The system will maintain resolution that enables facial recognition and vehicle license plate at a distance. Back-up capabilities are in order in case of a power outage. Cameras are placed on the interior and exterior of the building, but never in sleeping quarters or bathrooms. Video surveillance system is only accessible to designated personnel. A supervisor will review the tape on a bi-weekly

basis at the minimum and note in the logbook, which will include a random sample of overnight shifts. All cameras are visible to persons in the areas and a written notice is posted on the premises. Third party review after a request from a program quality improvement visits and when an investigation is pursued after an allegation.

The program has multiple video surveillance cameras in both the exterior and interior of the shelter where the youth, staff, and visitors congregate. The cameras are all visible and there are no hidden cameras on site. There are multiple signs stating that the program does have video surveillance to notify youth, staff and visitors they are being taped. There are no cameras in the youths' dorm rooms or bathrooms. There is a backup generator that can last up to 45 days if there is a power outage that would keep the camera system still in working function.

There is a log book specifically for the supervisory review of video tape. The shelter supervisor documented they reviewed tape at a minimum of every 14 days, including random samples of overnight shifts. The review log also documents any notes for improvements needed or noticeable good deeds. There is a process involved for third party review of video surveillance after a request from program quality improvement visits and when an investigation is pursued after an allegation of an incident. The video surveillance system can capture and retain video photographic images if needed. The video surveillance system can record date, time, location and can store video for a minimum of 30 days. A list of supervisors and designees who can review the video system is highlighted and hanging in the direct care worker's office.

Exceptions:

No exceptions are noted for this indicator.

Standard 4: Mental Health/Health Services

Overview

The Arnette House program provides screening, counseling, and mental health assessment services. The agency has a Shelter Program Manager that oversees the daily operations of the youth shelter. The Arnette House program has direct care staff members that are trained to screen, assess, and notify all staff members of conditions and risks of all youth admitted to both Residential and Non-Residential CINS/FINS programs. The agency utilizes screening and risk factor identification techniques to detect youth referred to their programs with mental health and health related conditions. Specifically, the agency uses a multistep screening form that combines the components of the initial screening and the CINS Intake form to determine CINS/FINS eligibility status and the presence of risks. The form also captures the youth's past mental health status, as well as, their current status.

The agency also screens for the presence of acute health issues and the agency's ability to address these existing health issues. The Arnette House Residential program assists in the delivery of medications to all youth admitted to the youth shelter with medication or over the counter medications that are prescribed by a Physician. The agency operates a detailed medication distribution system using the Pyxis Med-Station. The agency provides medication distribution training to all direct care staff members including first aid, CPR, fire safety, emergency drills and exercises, and training on suicide prevention, close watch observation, and crisis intervention techniques. Agency staff members are also required to notify parents/guardians in the event that a resident has a health issue or injury during their shelter stay.

4.01 Healthcare Admission Screening

☒Satisfactory ☐ Limited ☐Failed

The agency has a written specific policy for Health Screening on Admission. It was last revised on May 29, 2018 and reviewed on December 10, 2018 by the CEO.

The agency's policy ensures that the youth admitted to shelter care be placed in general population and that the youth is not in need of immediate medical attention. All youth are provided preliminary physical and mental health screening at the time of admissions to ensure no immediate concerns of mental or health conditions which renders admission unsafe.

The procedures state the Intake Assessment Form is to be completed upon admission. Information on this form should include: history of suicide attempts; current or past

substance abuse; current medications for mental or physical health; inquiry in to symptoms of active tuberculosis; physical/dental health problems; medications; allergies; recent injuries or illness; and presence of pain or other physical distress upon admission. A preliminary screening should include observation of the following: evidence of illness; obvious injury; and presence of scars, tattoos, and other skin markings. The Shelter Program Manager shall be notified if the screening form indicates any serious medical, mental health, or dental conditions, in order to make a decision about the admission and/or the need for immediate medical attention.

There were seven files reviewed. Of the seven files reviewed, four of the youth were on medication. One youth had asthma. All seven youth had some type of mental health diagnosis and/or drug use identified. These conditions were documented in the file and also entered into the shelters alert system. There are procedures in place for follow-up care if it is needed. None of the files reviewed required any type of follow up care. The agency has a separate form that documents the observation of scars, marks or tattoos.

The Registered Nurse (RN) conducts a Facility Entry Physical Health Screening form on all youth admitted to the program. This is an additional health assessment/screening record maintained exclusively for the RN. The RN keeps these records and retains these documents for chronic youth that return to the shelter for service needs. This screening was provided for all seven files reviewed and documented it was completed within five working days of the youth's admission to the shelter.

Exceptions:

No exceptions are noted for this indicator.

4.02 Suicide Prevention

☒Satisfactory ☐ Limited ☐Failed

The agency has a Suicide Protocol policy in place. The policy was last revised on May 29, 2018 and reviewed on December 10, 2018 by the CEO.

The agency's suicide prevention procedures require that the agency have a standardized suicide risk screening process. This process requires that the agency screen all residents using the CINS/FINS Intake Screening questions established by the Florida Network of Youth and Family Services. The agency also has a comprehensive suicide assessment risk questionnaire that is administered on each shelter resident. Once a resident is deemed positive for suicide risks, the agency then places them on elevated supervision watch; administers a suicide assessment overseen by a clinician; maintains observation counts while the resident is on supervision status; and does not change the status unless approved by an agency clinician.

The agency requires that all direct care staff members receive training on how to properly screen applicants for any potential suicide risks. The agency's shelter is equipped with suicide intervention tools that include a knife-for-life and wire cutters. The agency also requires that all direct care and counselors document the status of the youth in both logbook and client case file.

The agency has a total of two Licensed Mental Health Counselors (LMHC) on staff. Each of these staff persons had documented proof of their respective clinical licenses that were in effect and supplied copies on site. In addition, the shelter also has counselor who is a registered mental health intern and also another master's level certified mental health counselor.

There were four files reviewed of youth placed on suicide precautions. All four youth were placed on suicide precautions during the intake process due to positive results on the CINS Intake Screening form. All four of these screening forms were reviewed by a supervisor. Each youth was placed on the appropriate level of supervision and an Assessment of Suicide Risk was completed, in each case, within twenty-four hours. Out of the four files, three of the Assessments of Suicide Risk were completed by an unlicensed professional and one was completed by the LMHC. All three assessments completed by the unlicensed professional documented a signature, indicating a review, by the LMHC. Two of these three reviews took place the same day the youth was removed from suicide precautions, indicating the supervision level was not changed until reviewed by the licensed professional. The third review by the licensed professional took place three days after the youth was removed from suicide precautions. All four youth documented observations, in increments of ten-minutes were maintained the entire time the youth were on suicide precautions.

Exceptions:

No exceptions are noted for this indicator.

4.03 Medications

☒Satisfactory ☐ Limited ☐Failed

The agency has a policy that is called the Medication Distribution for Non-Health Care Staff. The policy was last revised on May 29, 2018 and reviewed on December 10, 2018 by the CEO.

Upon admission to shelter services, the youth and parent or guardian shall be interviewed about the youth's current medications. This shall be part of the Medical and Mental Health Assessment screening process. Only medications from a licensed pharmacy, with a current, patient-specific label intact on the original medication

container may be accepted into shelter. In order to verify the medication staff must contact the pharmacy by phone and document who they spoke with.

There are detailed procedures in place for the delivery or assisting in the self-administration of medication. Under no circumstances may a prescription medication be removed or pre-poured from its original package or prescription container and placed in another container for subsequent delivery or administration. There were no procedures in place for the inventory of medications or sharps. There were also no procedures in place for the disposal of medication, if needed. Lastly, there were no procedures in place for a monthly review of medication management practice via the Knowledge Portal or Pyxis Med-Station Reports.

The agency utilizes two forms in the process to assist in the delivery of medications to youth. The agency uses a Medication Distribution Log (MDL) to document all medications provided to all youth during their shelter stay. The MDL captures name, date of admission, reason for medication, dosage, time(s) of day, method of distribution (oral, topical, injection, inhalant, etc.), doctor, side effects, allergies, staff signature, youth signature, and general comments. The second document that the agency uses is called the Client Medication FACE Sheet. The FACE Sheet lists morning (am) medications, afternoon (pm) medications, alternative time, PRN medications, and a listing of staff members that distribute the medications.

The agency has a total of eleven Users that have been trained and are authorized to utilize the Pyxis MedStation 4000 Automated Cabinet. Of these eleven Users, four are Super Users. The agency has a Registered Nurse (RN) employed with the agency since January 2016. The RN works in the shelter overseeing the medication distribution process two to three days per week mostly during morning hours. The RN is also the primary person in charge of training all non-licensed staff authorized to distribute medication to residents. The agency uses the Pyxis Med-Station to store all controlled, general prescription and over the counter medications. Inspection of the Pyxis Med-Station 4000 resulted in findings that indicated that all medications including controlled, prescription and over the counter medications were all stored in separate cubie storage bins in 1 of 5 drawers in the cabinet. The RN demonstrated full access and familiarity with the operation of both the Medication and the Console. The RN also completes inspections of inventories conducted since the last time that she was on duty. The Nurse’s duties include monthly inspection of all first aid kits and conducts group exercises with residents in the shelter on a weekly to bi-weekly basis. The RN retains a group binder with a sign-in log to document all group activities. The RN also conducts a facility physical entry form on all clients admitted to the program. This is an additional health assessment or screening record maintained exclusively for the RN. The RN keeps these records and retains these documents for chronic youth that return to the shelter for service needs.

The agency houses the Pyxis Med-Station 4000 Cabinet and mini medication refrigerator in the locked Direct Care Worker office. The Med-Station is self-contained and requires a passcode and biometric finger print scanner that grants permission to access the medication. The mini-refrigerator has a key lock and thermometer as required.

The RN reported that the agency maintains all counts on controlled medications and conducts these counts three times per day, at the end of each work shift. The agency conducts regular prescription medication two times per day and over the counter medications two to three times per week or when given. Sharps are secured as required and the agency does not have to accept syringes. The agency has counts documented for all medications recorded. All counts reviewed were accurate and completed as required.

The agency completes reviews of the Pyxis to ensure that discrepancies are cleared out of the cabinet prior to the close of each work shift. The RN and the Shelter Manager check and verify discrepancies prior to clearing them from the system. They also have a detailed verification process and adheres to the major steps that include initiating contact with the pharmacy; verifying the label; and documentation of contacting and verifying medications with the pharmacy. The agency produces monthly Knowledge Portal or Pyxis Med-Station Reports. The RN produces three reports a total of three times per month on a routine basis. These reports include Critical Lows; CS Pockets Inventoried per Policy; and Discrepancy Audit Summary Reports.

There were four youth files reviewed to determine general adherence to program requirements. Of the files reviewed, all youth had evidence of the required medication forms including the MDL and the Client Medication FACE Sheet. The agency has a process that requires staff to alert the parent or guardian when a resident has a total of seven doses of their medication remaining.

Exceptions:

No exceptions are noted for this indicator.

4.04 Medical/Mental Health Alert Process

☒Satisfactory ☐ Limited ☐Failed

The agency has a policy for Medical, Mental Health and Substance Abuse Screening and Alert. The policy was last revised on May 29, 2018 and reviewed on December 10, 2018 by the CEO.

Staff completes a physical, mental health, substance abuse and suicide risk screening for all clients upon admission to the residential program. This screening will be conducted by completing a Screening Form, Risk Factor Form, Intake Assessment Form, Client Self-Assessment, ATOD, and the Client Injury/Limitation Form. The screening information will be documented on the admission data form, Medical and Mental Health Alert Form, Shift Review, Pass Down Log, the Medication Information and Dispensing Form, Progress/Chronological Notes, and an alert on the front of the case record as part of the Medical and Mental Health Alert System.

There were seven youth files reviewed. All seven files were active files of youth currently in the shelter. All seven youth had a medical, mental health, substance abuse, and/or allergy alert identified during the screening process and appropriately entered into the shelters alert system. The Medical and Mental Health Alert Form was found in each file that documented all identified alerts. The Shift Review Logs were reviewed for the previous three shifts and documented all applicable alerts were being consistently documented each shift.

The alert system includes a method to identify the client's condition in each file where staff can find basic precautions to be aware of relating to the current medical or mental health condition. The alert system also includes a way to advise and inform staff that the youth may be on prescribed medications.

A direct care staff was interviewed and found to have good general knowledge of the medical and mental health alert system. Staff are aware and know locations of where alerts can be found. Staff know the office where the alerts are maintained. In addition, staff are also aware of where the alerts are placed in each youth’s file. Staff are also familiar with how alerts can be updated and where the allergies are to be placed in the kitchen area prior to any residents receiving any food.

Exceptions:

No exceptions are noted for this indicator.

4.05 Episodic/Emergency Care

☒Satisfactory ☐ Limited ☐Failed

The agency has a policy in place titled Episodic/Emergency Care. The policy was last revised on May 29, 2018 and reviewed on December 10, 2018 by the CEO.

The program follows written procedures that ensure the provision of emergency medical and dental care. Procedures include notifying a youth’s parents when the youth is required to seek offsite medical treatment. An incident report must be submitted to the DJJ CCC and the Florida Network of Youth and Family Services within the required time

frame of two hours. The agency is required to maintain documentation related to any CINS/FINS resident receiving offsite emergency services. The agency has an official daily log where all offsite emergency incidents are maintained. Once a youth returns from receiving offsite emergency services to the shelter, the agency must verify receipt of an official medical clearance and any associated discharge instructions and follow up care required to be delivered to the youth.

First aid kits are located in each of the three vans, the shelter, kitchen, school house, and Brannon Center. These kits are checked once a month by the shelters RN. An inventory list is checked off for each kit and if items are replaced or replenished it is noted. These inventories were reviewed for the last six months. There are knife-for-life and wire cutters located in a box on the wall in the direct care workers office.

The shelter conducts episodic drills once a month on various shifts. There drills were reviewed and were found to be completed for the last six months.

The program has had four instances of emergency/episodic care in the last six months. All four instances were reported to the CCC. All had an internal incident report documenting the details of the incident and the notification of the supervisor, CCC, and the youth's parents. Follow-up communication with the CCC was reviewed, that indicated all cases had been successfully closed and discharge/follow-up instructions from the hospital were noted on all four incident reports.

Exceptions:

No exceptions are noted for this indicator.