



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Arnette House

on 12/13/2017

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 3: Shelter Care

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

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 4: Mental Health/Health Services

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

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

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

Rating Definitions

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

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

Review Team

Members

Keith Carr, Lead Reviewer, FOREFRONT/Florida Network of Youth and Family Services

Sherl Craft, MA LMHC; Counseling Supervisor, Lutheran Services Florida (Northwest)

Cassandra Houston, Program Manager, Youth and Family Alternatives, Inc. (RAP House)

Paul Czigan, Regional Monitor, Department of Juvenile Justice

Travis Scott, Residential Counselor, CDS Family and Behavioral Health Services

Persons Interviewed

- | | | |
|---|--|---|
| <input checked="" type="checkbox"/> Chief Executive Officer | <input type="checkbox"/> Executive Director | <input checked="" type="checkbox"/> Chief Operating Officer |
| <input checked="" type="checkbox"/> Chief Financial Officer | <input type="checkbox"/> Program Director | <input type="checkbox"/> Program Manager |
| <input type="checkbox"/> Program Coordinator | <input type="checkbox"/> Direct- Care Full time | <input type="checkbox"/> Direct-Care Part Time |
| <input type="checkbox"/> Direct-Care On- Call | <input type="checkbox"/> Volunteer | <input type="checkbox"/> Intern |
| <input checked="" type="checkbox"/> Clinical Director | <input checked="" type="checkbox"/> Counselor Licensed | <input checked="" type="checkbox"/> Counselor Non- Licensed |
| <input checked="" type="checkbox"/> Case Manager | <input type="checkbox"/> Advocate | <input checked="" type="checkbox"/> Human Resources |
| <input type="checkbox"/> Nurse | | |
| 2 Case Managers | 1 Maintenance Personnel | 2 Clinical Staff |
| 0 Program Supervisors | 0 Food Service Personnel | 1 Other |
| 0 Health Care Staff | | |

Documents Reviewed

- | | | |
|---|--|--|
| <input checked="" type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input checked="" type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input checked="" type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Fire Drill Log | 8 # Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 4 # MH/SA Records |
| <input checked="" type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 8 # Personnel Records |
| <input checked="" type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 10 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 8 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 6 # Youth Records (Open) |
| <input checked="" type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 3 # Other |

Surveys

8 Youth 10 Direct Care Staff

Observations During Review

- | | | |
|--|--|--|
| <input checked="" type="checkbox"/> Intake | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input checked="" type="checkbox"/> Program Activities | <input type="checkbox"/> Tool Inventory and Storage | <input checked="" type="checkbox"/> Facility and Grounds |
| <input checked="" type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage | <input checked="" type="checkbox"/> First Aid Kit(s) |
| <input checked="" type="checkbox"/> Searches | <input checked="" type="checkbox"/> Discharge | <input checked="" type="checkbox"/> Group |
| <input checked="" type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings | <input checked="" type="checkbox"/> Meals |
| <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input checked="" type="checkbox"/> Youth Movement and Counts | |
| <input checked="" type="checkbox"/> Medication Administration | <input checked="" type="checkbox"/> Staff Interactions with Youth | |

Comments

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

Rating Narrative

The agency had no examples of CINS/FINS Petitions since the date of the last on site program review in November 2016.

Strengths and Innovative Approaches

Rating Narrative

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 implemented some innovative approaches working with the CINS/FINS population. They include a vocational training and preparation program; an updated day room; the implementation of leadership opportunities for residents during daily activities schedule; daily work break planning where management replaces direct care staff in the shelter to supervise residents and summer camp week conducted last Summer 2017.

Standard 1: Management Accountability

Overview

Narrative

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

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy (OA HR 3.03) addressing background screening, which covers new hires for applicants, independent contractors, volunteers and interns. The policy also includes the conducting of five-year rescreenings of employees and submission of an Annual Affidavit of Compliance with Level 2 Standards. The policy was signed by the Chief Executive Officer 4/4/2013 with annual reviews documented on 1/27/2015 and 3/16/2016.

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 for 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.

Post Hire Arrest: Any employee arrested while employed by the Arnette House, must immediately report the arrest to their program coordinator or supervisor and supply a copy of the arrest report. The coordinator/supervisor must make an incident report to the Central Communications Center of the Department of Juvenile Justice (see "Incident Reporting Procedure" and Incident Report Forms). A criminal background check will be conducted by the agency to determine if there are any charges pending. The supervisor will conduct an investigation into the charges and present investigative findings to the Chief Executive Officer. A determination will be made by the CEO, depending on the severity and type of charges, regarding whether the staff member's continued employment is allowable by statute or in the best interest of the clients and the agency.

The employee may be placed on administrative leave until the CEO makes a decision pending the outcome of the investigation. A decision may be made to wait until the final outcome of the court process, however, any conviction on a charge that would bar an employee from being initially hired will result in termination. The Department of Children and Families and/or the Department of juvenile Justice may, based on the charges, conduct their own investigation. If they determine an arrest or conviction excludes a staff from employment with one of their providers through contract, policy, or statute, agency will terminate the employee. Throughout the judicial process the employee must keep management apprised of upcoming court dates and the progress of the case. After an employee has gone through the judicial process they must bring a copy of the final disposition of the case to their program manager. A copy of the disposition will be placed in the employee's personnel file.

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 11, 2017.

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

Two staff were eligible for five-year rescreenings. Both staff files contained an eligible rescreening. One staff's hire date was listed as 1/16/2007; therefore, her rescreening due date was 1/16/2017. However, her rescreening was submitted 1/11/2017 and completed 1/17/2017, one day late. The request for rescreening was not submitted at least ten days prior to the hire date five-year anniversary.

Exception:

One staff's hire date was listed as 1/16/2007; therefore, her rescreening due date was 1/16/2017. However, her rescreening was submitted 1/11/2017 and completed 1/17/2017, one day late. The request for rescreening was not submitted at least ten days prior to the hire date five-year anniversary.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy regarding provision of an abuse free environment. The policy includes each staff is responsible for the program's code of conduct. Three policies were pertinent to provision of an abuse free environment: Discipline, control and punishment policy 65-C14.021, discipline and termination, ST-C0019, and abuse reporting.

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 was one grievance in the binder under the month of February 2017. The grievance was resolved by staff on the third business day following submission of the grievance. The grievance did not require an appeal to the supervisor/administration.

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.

Eight youth were surveyed on the first day of the review regarding their experiences at the shelter. Eight youth were surveyed regarding how safe they felt in the shelter. None of the youth answered the question. However, in response to another question, three of the eight said they felt safe in the shelter. All eight youth indicated on the survey they know the abuse hotline is available to report abuse at the shelter. All eight youth responded "no" to the question "have you heard adults use curse words when speaking with you or other youth?" Seven of eight youth responded "no" to the question "are the adults here respectful when talking with you and other youth?"

There were no responses to the questions "are you denied food at the shelter?" and "have you heard any adults threaten you or other youth?" All eight youth said they had been denied clean clothing at the shelter. Seven of eight youth indicated they receive mental health care at the shelter.

It appeared the youth either did not understand the questions, or were uninterested in responding to the survey. On the second day of the review, the team took another survey with six youth (not all of the eight previous youth were present) using the same questions, but manually scored the youth responses.

All six youth indicated on the survey they know the abuse hotline is available to report abuse at the shelter. Five youth responded no to the questions "have you heard adults use curse words when speaking with you or other youth, and have you heard any adults threaten you or other youth?" One youth was not asked these two questions. All six youth responded "yes" to the question "are the adults here respectful when talking with you and other youth?" All six youth said they had not been denied clean clothing at the shelter or denied food. All six youth indicated they had received medical care at the shelter.

Exception:

Although the one grievance was resolved within the time frame, the resolution was not signed by the youth grieving the issue.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

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.

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 then submitted to the Program Quality Improvement (PQI) committee for approval and implementation of the recommendations.

All five incidents reported to the CCC were found documented in the logbook. Several were noted as a late entry in the logbook. The program had five 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 five incidents. Each of the five 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.

Exception:

During a review of logbooks, it was observed, staff inconsistently documented incidents according to the program policy and procedures, specifically including law enforcement. Instances observed usually included the name of the officer involved, but did not include the following: Officer's Identification number, case number.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The program has three policies regarding training: Orientation, training and staff development, and Mandatory Training.

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).

The three staff training records were reviewed for compliance with training in the first 120 days and first year of employment. One staff was out on medical leave for thirty-six days in the first 120 days. However, she completed most of her mandatory training. By the time of the review, she had completed the missing three courses.

The other two staff completed all required training within the required time frame. Although only one of the three new-hire staff had completed one year, all had received in excess of eighty hours of training.

For in-service requirements, the review team considered seven staff training records, two from the morning shift, two from the afternoon shift, one from the night shift and two supervisory staff. All seven staff received the required forty hours of in-service training in most required areas. All seven averaged fifty-eight (from forty-three – ninety-six) hours in excess of the required in-service training hours. Three staff files did not document training in PREA and three did not document training in Managing Aggressive

Behavior.

Training in suicide risk assessments:

Two staff holding master's degrees in counseling provide mental health and substance abuse treatment services to youth in the shelter. There was documentation in each of their training records the licensed clinician provided training in the risk assessment instrument March 30, 2016 including twenty hours and the co-facilitation of five assessments.

Exception:

In-service training: Three in-service staff training files did not document training in Prison Rape Elimination Act (PREA) and one of those three did not document training in Managing Aggressive Behavior.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place that states they will collect data and analyze it on a monthly basis, ensuring the program keeps up with the Continuous Quality Improvement plan developed by the agency. The policy was revised 7/01/12 by the CEO, and then reviewed 4/15/15, 10/26/16 and 10/31/17 by the CEO as well.

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.

There were no exceptions found.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy regarding transportation which includes drivers avoid situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth.

Procedures include only staff with a valid Florida driver's license and approval of the insurance company are allowed to drive agency vehicles. Further, trips must include at least two staff members while transporting only one youth, unless there is supervisory approval. Procedures also include the agency insurance company is responsible for coverage of all transportation events. The program will maintain a vehicle log for all occasions in which youth are transported.

The van log was reviewed for November 1 – December 8, 2017. 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). A review of all the trips with one passenger/youth revealed documentation of the supervisory approval, and time of approval. Each entry included the driver's initials or signature.

There were no exceptions found.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has a specific written policy on community outreach services. It was last reviewed on 03.10.16.

The agency indicated in their policy to participate in local DJJ board and council meetings to ensure CINS/FINS services are represented in a coordinated approach to increasing public safety by reducing juvenile delinquency through effective prevention and intervention. The program also maintains written agreements with other community partners that include services provided and a comprehensive referral process.

The program had documentation indicating attendance at the January 2017 DJJ Circuit Advisory Board.

Reviewer interviewed a member of management who also serves on the Circuit 5 Local Review Team and had documentation of participating in meetings.

The program documented meetings with various community agencies and attendance at activities or functions related to youth services. The agencies included but were not limited to the Marion County Children's Alliance, Kids Central, Non-Profit Business Council, United Way Program, education agencies, Premier Pediatrics Community Fair (promoting safe place), Education Vision Council, Back to School Bash (promoting safe place), Village View Church Day, Continuum of Care Partner Meeting. 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.

The program had interagency agreements or memorandum of service delivery/collaborative relationships with several community service agencies, police agencies, medical providers, education services, and mental health and substance abuse providers. Documentation reviewed found the agreements are updated annually. The recent agreements or updated agreements include the following agencies:

- Marion County Homeless Council (08/04/16)**
- Ocala Housing Authority (08/08/16)**
- Lake County Sheriff's Office (08/18/16)**
- Marion County Sheriff's Office (08/29/16)**
- Ocala Policy Department (08/12/16)**
- Interfaith Emergency Services (7/19/16)**
- National Runaway Safeline (06/07/17)**
- American Red Cross (06/07/17)**
- National Safe Place Network (04/19/16)**
- Express Care of Ocala (7/25/16)**
- Premier Pediatrics (8/17/16)**
- Marion County Health Department (9/15/16)**
- Munroe Regional Medical Center (8/5/16)**
- Heart of Florida Health Center (8/2/16)**
- School Board of Marion County (08.08.17)**
- Pace Center for Girls of Marion County (02/11/17)**
- Citrus Levy Marion Regional Workforce Development Board (7/19/16)**
- Citrus Hearing Impaired Program Services (7/26/16)**
- Marion County Public Schools (6/14/16)**
- CDS Family & Behavioral Health Service, Inc. (05/05/17)**
- Kimberly's Center for Child Protection (8/10/16)**
- The Centers (05/30/17)**
- Children's Home Society (7/8/16)**
- Silver River Mentoring and Instruction (7/27/16)**
- Boys and Girls Club of Marion County (7/25/16)**

Exception:

On day one of the onsite review there wasn't an Arnette House specific policy found for this indicator. The reviewer inquired about the policy from management. A dated policy (07/01/2012) was presented to the reviewer and the reviewer then inquired about a more updated version. The interviewee indicated an updated version will be presented on day two of the onsite review (12/14/17). On day two of the onsite review, an updated policy on Community Outreach Services was provided to the reviewer as instructed. It was last updated on 03/10/16.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

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

Rating Narrative

Agency has written policies and procedures in place to address intake and screening. Screening policy was last reviewed on 3/10/16 by the CEO. Intake policy was revised on 9/16/2015 by the CEO.

Agency procedure states that program has a 24 hour screening process via phone. Procedure states that screenings are completed within 7 days of being referred to the agency. Intake is conducted within 7 days of initial screening. If family is determined to be ineligible for service, procedure states that referral is made to other agency.

During intake process, the family is made aware of rights and responsibilities of parent/guardian and child as well as available services and treatment options. Grievance procedures are also reviewed during intake along with possible action occurring through CINS services.

Eight files were pulled by random selection to include the following: 2 open res, 2 closed res, 2 open non-res, and 2 closed non res. Of the eight, seven were determined to meet 7-day eligibility. All files were noted to have evidence of the following information received by the parent/guardian and child by way of signatures: information regarding available service options, rights and responsibilities of youth and parents/guardians and possible actions through CINS/FINS services. All files also contained a grievance procedure form.

Exceptions:

Of the eight files reviewed, one file was missing a date on the screen therefore 7 day eligibility was unable to be determined.

Receipt of the Parent/Guardian brochure is notated by a yes or no but it is unclear what the yes or no relates to without asking.

Although grievance forms were located in all files, two of the eight files were missing client signatures on the form as well as one was missing a parent signature.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

Agency has a written policy and procedure in place to address Needs Assessment being completed within 72 hours for shelter clients or within 2-3 face to face meeting for non residential clients. Policy was last revised on 9/16/15 and was reviewed on 10/13/16 each time by the CEO.

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 for suicide, suicide assessment has to be reviewed or written by a licensed counselor.

Eight files were pulled by random selection to include the following: 2 open res, 2 closed res, 2 open non-res, and two closed non res. All residential files had intake completed with 72 hours and all non-res files had intake completed on within 2 meeting.

Agency practices demonstrated completion of needs assessments Bachelor's or Master's level counselors. All files reviewed had completed Needs Assessments with all required signatures including supervisor. Of the 8 res files reviewed, 2 were noted to be at elevated risk for suicide. Suicide assessments were completed by staff and signed by a licensed professional.

There were no exceptions to this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

Agency has a written policy in place for development, implementation and review of the the case/service. Policies were last reviewed on 3/10/2016 by the CEO.

Agency procedure states that case plans are developed with the youth, parent/guardian and counselor/case manager within 7 days of the completed Needs Assessment. If the youth is admitted under an emergency status, case plan is initiated within 24 hrs of admission. Procedure states that reviews are conducted every 30 days for the first 3 months and every 6 months thereafter for non-residential and every 2 weeks for residential clients.

Parent signatures are obtained during reviews/revisions and parents are given a copy of the plan. Procedure states that case plans are reviewed and signed by a licensed professional. The agency's case plans include identified needs and goals, type, frequency, and location of services, person(s) responsible, target date(s) for completion, actual completion date(s), signature lines for all parties involved, and date the plan was initiated.

Agency practices demonstrated completion of all case plans on the same day as need assessments. All case plans contained dates that the plans were initiated. All files noted individualized goals with service

type, location, target dates, and frequency. Responsible parties were also noted on the case plan with targeted completion dates. All files had parent and counselor signatures on the case plan. Three of the four non-residential files reviewed were updated/reviewed every 30 days.

Exceptions:

All files were missing completion dates on the case plan.

Three of the four non-res files were missing client signatures on the case plan.

One of the eight files was missing a supervisor signature on the case plan.

2.04 Case Management and Service Delivery

Satisfactory Limited Failed

Rating Narrative

Agency has a written policy to address case management and service delivery. Policy was last revised on 3/10/16 by the CEO. Policy includes the following: planning of services, monitoring family/youth progress, service plan coordination, referral services, advocacy services, case staffing, filing CINS petitions, supportive services to families including attending court with families and/or providing documentation for court and continued case monitoring and review of court orders.

Policy states that agency case managers coordinates 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 on going 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.

A total of six cases were pulled at random for this indicator. Two of the six files reviewed were open to services currently. All cases had an assigned case manager who attended all court proceedings with client and parent. Out of the 6 files reviewed, 5 were noted to have had referrals made. Referrals were made to a vary of services including psych evals, family counseling, tutoring Big Brothers Big Sister, substance abuse counselor, and residential services. Of the 6 files reviewed, 5 had to be placed in out of the home which was shelter services at Annette House. (Although referrals were noted, the information was difficult to locate within the file given how lengthy the files become due to numerous court documents in the file and extended involvement in services. It is also unclear how follow up on and tracking of referrals occur.)

Monthly monitoring was conducted on all 6 cases. All follow ups were completed for closed files. Five out of the six cases had documentation of case staffing with involvement from other local service providers and family at the staffing. The one case that did not engage in case staffing moved directly to having a CINS petition filed.

Three of the six files had consistent contact with the child. Support to the family focuses mainly around meeting with the child at school, case manager's presence in court with the family and on going attempting to meet with the parent.

There were no exceptions to this indicator.

2.05 Counseling Services

Satisfactory Limited Failed

Rating Narrative

Agency has a policy in place to address counseling services. This was last reviewed on 10/12/2016 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 on going case reviews by the supervisor.

Eight files were pulled by random selection to include the following: 2 open res, 2 closed res, 2 open non-res, and two closed non-res. All files were noted to have case plans that were related to the initial needs assessment. Individual sessions were conducted as outlined on the service plan.

Non-res counseling is conducted primarily in the school through group counseling. Individual counseling is also implemented as needed. One of the four non-res files demonstrated involvement in individual counseling carried in the school. Parent involvement occurs primarily at intake and discharge.

Group counseling is conducted 5 days a week in shelter and youth are groomed to be peer leaders thereby becoming examples and role models for other youths in shelter. Youths are strongly encouraged to lead group sessions throughout the week which allows for positive peer support.

Exceptions:

Residential group notes are kept in a binder but all notes were missing duration. Several of the notes also lacked details related to topics and how topic was carried out.

Of the eight files reviewed, one was missing documentation on going internal review by the supervisor.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy for the case staffing committee (CSC) and adjudication/petition process. It was last reviewed on 03.10.16.

A case staffing is scheduled to review a case that the program determines a need of services if youth/family have not demonstrated substantial progress in achieving goals, family youth will not participate in the services or treatment selected, service delivery/treatment have not addressed the problems and needs of family and parent, guardian or custodian of an active CINS/FINS youth requests in writing that a case staffing committee be convened.

The procedure in place outlines the composition of the CSC shall be based on the needs of the family and include but not limited to the following: Case manager, representative of youth's school district, representative of DJJ, representative of or from area of health, mental health, substance abuse, social, or educational services. Time and place selected for the CSC must be convenient for the youth/family. A certified letter is sent to the family with date and time indicated. All parties assembled for CSC are contacted within 5 working days to confirm meeting. CSC will make a series of recommendations, which may include the filing of a CINS petition, additional services, or referrals to other agencies. If a family is not present for CSC, the filing of CINS petition (accepted or denied) will be mailed by certified mail within 5 days of CSC meeting. The case manager is responsible for overseeing the case in its entirety. Within 30 days of a petition being recommended the assigned CINS case manager should have the petition and Judicial packet assembled.

Three files were randomly selected for this indicator—two open and one closed. In one open file reviewed, the date of the screening wasn't indicated. However, after interviewing the clinical supervisor, the reviewer was able to establish that the screening and intake were completed on the same day. All files met the requirements of the indicator.

There were no exceptions for this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy for youth records. It was last reviewed on 03.10.16.

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.

There were eleven files reviewed for this indicator and all files met the minimum standards for this indicator. File room locations were directly observed and found to meet the standards of this indicator.

In addition, the clinical supervisor was interviewed regarding youth records. The clinical supervisor was able to articulate the policy, procedure, and practice of youth records.

There were no exceptions for this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

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 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

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 3/21/12, 3/10/14 and 9/16/15 by the CEO, and then reviewed 1/27/15, 3/10/16, 10/31/16 and 10/31/17 by the CEO as well.

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.

Health and fire inspections were completed and current. Shelter furnishings appeared to be in good repair, some had normal wear and tear expected. Recently the program has gotten new beds, a pool table, sound boards and new washers and dryers. The program did not appear to have any insect infestations. The grounds were clean and well maintained. The outdoors had a great variety of activities for youth to engage with: rock wall climbing, basketball hoops, place to run/walk, canoeing, and a adequate places to sit. The bathrooms and showers were clean and functional. There was no apparent graffiti on anything. The program recently used chalkboard paint to paint one wall in each of the youths' bedrooms to reduce the amount of unwanted graffiti. These walls depicted mostly positive messages and drawings. 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 has adequate places for the youth to lock up belongings to ensure safety of them. The program engages at least one hour of physical activity with the youth each day. During the tour staff took youth outside and ran laps with the youth, then allowed them to choose an outside activity of their choice. There is a daily schedule that maps out the program's daily structured activities to keep them engaged. Youth are given the opportunity to engage in

faith-based activities, this is evident in the fact there is a bible study group the youth are allowed to join in if they so choose to. The program utilizes home schooling methods if the youth is not enrolled in the zoned schools of their area. The program has 2 different libraries of books that the youth can choose from to read. A general daily programming is displayed in the youths' dorm hallways for the youth to see. Then there is also a detailed daily programming to that specific day that is written out in the day room for the youth to review.

There were no exceptions for this indicator.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

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 9/16/15 by the CEO, and reviewed 10/31/16 and 10/31/17 by the CEO as well.

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.

The program has a detailed client handbook that is given out to each youth at the time of intake, or within 24 hours. The program has both the youth and their guardian sign stating the youth received said handbook. This writer reviewed four client files, out of those four files every youth received their handbook at the time of intake and both the youth and their guardian signed for it.

In the orientation process the following are included and discussed with the youth and their guardian: disciplinary action explained, the grievance procedure explained, emergency/disaster procedures, a list of contraband and the rules of such contraband, suicide prevention, room assignments, daily activities reviewed, a physical map of the shelter is provided with information written with it, and how to access the abuse line. Out of the four files this writer reviewed, all four had signatures from both the youth and the guardian stating the staff went over the information.

There were no exceptions documented for this performance indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place that states they will interview all youth upon admission to determine the most appropriate sleeping arrangements to ensure safety of all clients. The policy states that staff should make every effort to separate/segregate dangerous residents from those who are not, or they will provide alternative supervision if they cannot separate them. The policy and procedures were revised 9/12/13 by the CEO, and then reviewed 1/27/15, 3/10/16, and 10/31/17 by the CEO as well.

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.

The program has a room assignment sheet for the youth, to be completed upon intake. The form has the following information that is answered: the youths' age, the youth's gender, the youth's history of violence, the youth's disabilities, the youths' size, if the youth has any gang affiliation, the youth's suicide risks, and if the youth has a history of being sexually aggressive. There is an area to make additional comments, such as: if a youth identifies as a different gender than their birth gender, the youth's history of trauma, alerts information, any outside information that has been presented, and any initial interactions the staff observed with the youth. This writer reviewed four files, out of those four files all four had the room assignments completed full with details. The program keeps an alert board for all the youth in the direct care worker's office.

There were no exceptions documented for this performance indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place that states they will maintain a chronological account of all events that occur. The program will utilize a physical or electronic notebook that can capture all needed elements or entries. This policy was revised 5/16/17 by the CEO, and then reviewed 10/31/17 by the CEO as well.

The program has procedures in place that the log book contains observations on general atmosphere of the milieu and notable behaviors of the clients and staff. At minimum the program utilizes the log book for the following: emergency situations, incidents, events, drills, medication administration, when a youth is placed on or off supervision and monitoring, youth group movement, head counts, transports away from the shelter, searches, supervisory review of video surveillance, requests by any person to access any youth and their relation to that youth, home visits, admission and discharges, and information about any successful or attempts of absconion.

The program states the log book should contain the following elements: date and time of entry, date and time of incident/event/activity, a brief statement providing information, names of youth and staff involved, and the name and signature of the person making the entry. Any writings that may impact the security or safety of the program are highlighted in assigned colors. All errors are struck with a single line, initialed and dated, they cannot be deleted from the notebook. The program director or designee reviews the logbook on a weekly basis and will make notations. When a supervisor or counselor comes on to shift, they review the log since their last entry to become aware of any important information. They will then print out important information for the direct care workers to look over before their shift. The logbook remains confidential and the program retains them for a minimum of 7 years. All users are added and deleted by a supervisor, and each staff has a login and password.

The program has been utilizing an electronic notebook for their logbook since July 2017. This writer randomly selected dates within the last six months to review entries. All entries were detailed with the following required information: brief and understandable entries, the names of youth and staff involved, the date, the time, the recorder's name and either a signature or pin code was recorded. One recorded error was reviewed by this writer. The entry had one line crossed through it, documented that is was an error and signed by the recorder. The program supervisor, or designee, reviewed the log book at a minimum once a week and provided information to the direct care workers to review.

Every shift reviewed by this writer had documentation that all direct care workers and assigned working supervisors reviewed the log book of the previous two shifts at a minimum. The log book allowed the staff to tag the entries according to key notes, such as: fire drills, log review, medication time, incidents, discharges/intakes, home visits, etc. Important information was highlighted for easy access to the entry. Head counts, visits and incidents were documented upon review.

There were no exceptions documented for this performance indicator.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place that states that they are utilizing a point system with the youth. The program is also using peer leaders who work directly with the staff and other youth. They recognize the youth with personal achievement rewards as well with concrete rewards in variety of forms. The program also utilizes the RAPS problem solving process that involves the youth to help brainstorm ideas. To ensure safety the program has developed procedures to work with behavioral interventions. The policy and procedures were revised 7/1/12 and 12/5/13 by the CEO, and reviewed 12/11/14, 1/26/15, 3/10/16 and 10/31/17 by the CEO as well.

The program has procedures in place that upon admission the new youth will be assigned a peer leader to complete the orientation which outlines the point system to the youth. The programs has four main points to remember: setting the proper tone at intake with the youth and family for a smooth transition, an evening closure to set and review their goals, the use of natural and logical consequences, and the process to debrief behaviors and the consequences that follow.

The program has procedures in place that do not allow punishment in the following: physical punishment, verbal abuse, emotional abuse, assigning excessive exercise or work duties, or deny food, clothing, shelter, medical care, therapeutic activities, contact with family, counselors, and/or legal representation. The program uses behavioral interventions as a last resort and utilizes the least amount of force necessary. Counseling, verbal intervention and de-escalation techniques are used prior to physical interventions. If a staff is required to physically engage a youth, only nationally recognized techniques are used that are approved by Florida Network from by a staff that is trained in such techniques.

The program has a very detailed written description of their behavior management system and it is explained at orientation. The program uses a point based system for positive reinforcement for the youth who are in compliance with the program rules and expectations. The program's written description breaks down how the youth can earn points throughout the day in each aspect of their daily routine. The program has a points board in the day room that displays how many points each youth has earned. The youth are able to use their points in the point's store, which has a great variety of rewards the youth can buy. The youth have peer leaders, these responsibilities are earned through behaviors to hold youth more accountable for their actions. Consequences used by the program are either natural or logical, but not punitive. Example given by staff was that if a youth is not following house rules, they may lose their pool table privileges for 24 hours but they will still be able to play cards.

The program has a grievance box for the youth to put their feedback in. This box is located in the day room and is locked for confidentiality. The program has implemented a RAPS group for when there is a conflict with a youth, the youth can call a RAPS meeting. When a RAPS meeting is called all youth must participate in listening to the problem and assist in giving solutions to help. 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.

There were no exceptions documented for this performance indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

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 4/04/13 by the CEO, and then reviewed 1/27/15, 3/10/16 and 10/31/17 by the CEO as well.

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.

The program has a policy in place that meets the general staffing ratio for both wake hours, one staff to six youth, and sleep hours, one staff to twelve youth. The program maintains a minimum of two staff members on shift during sleep hours consistently. The program scheduled at least one male and one female for each shift, including overnight shift. The program keeps a copy of schedules in a binder that is kept in the direct care worker's office for all staff to review. In the same binder, the program keeps a copy of the staff roster along with their contact information in the event of holdover or overtime when additional coverage is needed.

Staff document they have observed the youth every fifteen minutes, including when the youth are in their dorm rooms regardless if they are awake or asleep. The program is equipped with video surveillance cameras that are functioning, and they hold tape for a minimum of thirty days. In reviewing video surveillance, this writer reviewed 24 separate bed checks. Out of those 24, all 24 bed checks were completed on time every 15 minutes by the staff on duty. The video was showing the bed checks were being conducted 2 minutes differently than they were being documented. This was consistent in all 24 bed checks viewed by this writer so it was noted that the consistency was due to difference in clocks. Staff utilizes the clock on the electronic log book.

There were no exceptions documented for this performance indicator.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written specific policy for special population. It was last reviewed on 03.10.16.

The agency provides services for youth who are in need of domestic violence respite and probation respite. Domestic violence respite youth are screened into the shelter by a referring DJJ officer. Youth who are in need of probation respite will be referred to the agency with adjudication withheld. The agency collaborates with DJJ to determine youth eligibility. The agency does not provide staff secure supervision and did not have any youth who were identified as Domestic Minor Sex Trafficking.

Two files were review for this indicator—one DV and one probation respite. In the DV file, the case plan and needs assessment weren't completed due to the youth arriving at the agency on day one of the onsite review. The agency was still within the time frame noted in their policy for the completions of case plans and needs assessments. In the probation respite file reviewed, the agency met all requirements for this indicator.

There were no exceptions for this indicator.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

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 made effective 8/31/16 by the CEO, and then reviewed 10/31/17 by the CEO as well.

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 noted 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.

Exception:

It was noted that in the review of video surveillance log, there was no clear identifier of who was the supervisor reviewing the video surveillance. There is no clear way to ensure it was the shelter supervisor or designee reviewing the tape.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

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

Rating Narrative

The agency has a written specific policy for Health Screening on admission. It was last reviewed on 03.10.16.

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 procedure in place outlines (1) Intake Assessment Form is to be completed upon admissions (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 admissions). (2) A preliminary screening should include observation of the following: evidence of illness, obvious injury, presence of scars, tattoos, and other skin markings. The written practice also addresses the referral process and follow-up medical care.

Seven files were randomly selected for this indicator—five (5) open and two (2) closed. Of the 7 files reviewed, one of the youth was on medication. Three (3) of the seven files reviewed for this indicator had allergies documented during the healthcare screening process and had evidence of allergies documented on a sticker outside of the youth's file. The agency has a separate form that documents the observation of scars, marks or tattoos. The nurse also completes a healthcare screening form for all youths admitted.

The reviewer interviewed the agency's nurse and a direct care worker and both were able to articulate the healthcare admission screening process.

There were no exceptions for this indicator.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy for Suicide Prevention. The Arnette House policy for suicide prevention is a written policy to ensure that residents meeting CINS/FINS eligibility criteria are screened for past and current suicide risks. This policy is required to establish a standardized practice for monitoring the mental health and behavior status of youth in shelter and to establish consistent and on-going communication system to inform all staff of status of residents at all times. The policy also ensures that the status is communicated to the staff supervising youth in the shelter. The policy was last reviewed and approved by the agency's CEO on October 21, 2016.

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 reviewer for this indicator randomly selected four (4) client files that had documented evidence of meeting suicide risks per the agency's policy. All 4 client files had evidence that the agency properly screened each of these 4 clients during the intake process. The agency screening process includes the CINS/FINS Intake form with the six (6) risk screening questions reviewed and signed by a supervisor or designee. Each case file had documented evidence suicide risk screening results that verified the resident was properly placed on an appropriate level of supervision.

Each client file contained observation logs that included documented observations on each of the 4 residents' suicide status throughout the time that they were on elevated supervision. There was documentation supporting each counselor consulting with a clinician on the resident's status during and prior to removing from suicide status. Three out of 4 client files had evidence of licensed professional/clinician's consult and signature prior to the youth's supervision level being changed. The agency has a total of two (2) Licensed Mental Health Counselors/professional clinicians on staff. Each of these staff persons had documented proof of their respective clinical licenses that were in effect and supplied copies on site.

Exception:

One of the four client files reviewed did not have evidence of a Mental Health Status Section in the Assessment for Suicide Tool. One of the four client files reviewed did not have evidence of a signature of licensed clinician on the Assessment for Suicide Tool.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy that is called the Medication Distribution for Non-Health Care Staff. The policy was last updated with revisions and approved by the agency's Chief Executive Officer on November 14, 2016. The current policy addresses the agency's written policy related to the safe and secure storage, access, disposal and distribution of oral medication and pharmaceutical products by non-licensed staff members. The agency's policy lists its limitations related to what it is prohibited to be distributed in the

shelter. Limitations include any youth that are required to receive prescribed injectable medications. The policy does require that licensed health care staff be the primary person assisting in the delivery of medications if the licensed person is on duty. In general, a review of the policy does indicate that the contents address the major requirement for the effective delivery of medications to eligible clients accepted in the CINS/FINS program.

The agency has procedures for executing the delivery of medication, including medication inventory, storage, management, distribution and the disposal process. The agency requires that all staff members screen all potential clients prior to their admission for their past or present use of medications during the medical and mental health screening process. The agency requires that all medications be verified through a multi-step verification process prior to acceptance into the program. The agency policy also lists the required steps for all trained staff to complete the process for the delivery or assisting in the self-administration of medication. The agency procedures prohibit prescription medication from being removed or pre-poured from its original packaging or prescription container and placed in another container for subsequent delivery or administration.

The current policy does address written documentation of the use of the Pyxis Med-Station 4000 Automated Cabinet as the sole storage method for inventory and management all medication accepted in to the program. Narcotics and controlled policy does include written documentation of requirements for the monthly review of medication management practice via Knowledge Portal or Pyxis Med-Station Reports. The procedures also address the use of the PRN log for the distribution of PRN medications; medication distribution away from the shelter; discharge of youth with medication; and use of over the counter medications.

The agency utilizes two (2) forms in the process to assist in the delivery of medications to eligible residents accepted into the CINS/FINS program. The agency uses a Medication Distribution Log (MDL) to document all medications provided to all clients 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, client 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 ten (10) Users that have been trained and are authorized to utilize the Pyxis Med-Station 4000 Automated Cabinet. Of these 10 Users, four (4) 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 three (3) 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 Nurse 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 1 (DCW1) 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 2 times per day and over the counter medications 3 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's sharps counts were reviewed for the last 6 months. All counts were conducted as required except for the last half the month of November 2017. The agency maintains a total of seven (7) first aid kits. The RN is responsible for replenishing all first aid kits. The reviewer found documented evidence of inspections of all first aid kits, but the documentation practice in which the counts were conducted are inconsistent. The date that the first aid inspections and content counts are being completed was not always clear.

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 3 reports a total of 3 times per month on a routine basis. These reports include Critical Lows; CS Pockets Inventoried per Policy; and Discrepancy Audit Summary Reports.

A review of the two (2) active clients and four (4) closed client files were reviewed to determine general adherence to program requirements. Of the files reviewed, all clients 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 (7) doses of their medication remaining.

Medication must be disposed when left behind by a client after discharge for more than ten (10) days. Disposal requires two (2) individuals to verify and confirm that the medication is disposed of properly. Medication is destroyed by the registered nurse and a witness. The medication is required to be disposed of by grinding down the pills in a container to neutralize the medication and then it is dissolved in water and flushed in a toilet. Additionally, the agency has biohazard containers located on site in the DCW 1 and DCW 2 offices.

Exception:

All sharps counts were conducted as required except for the last half of the month of November 2017.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy for medical and mental health alerts. The name of the Arnette House policy for 4.04 is called Medical, Mental Health, and Substance Abuse Screening and Alert. The policy addresses the process for informing the agency staff members of the alerts used to identify medical, mental health, allergies, substance abuse, behavior and other conditions. The policy also ensures that these conditions are communicated to the staff supervising youth in the shelter. The policy was last reviewed and approved by the agency's CEO on October 21, 2016. A review of the policy does indicate that the agency has a medical and mental health alert system in place that ensures information concerning the medical condition, allergies, common side effects of prescribed medication and other conditions of youth accepted into the CINS/FINS program are addressed and communicated to all staff members.

The agency has procedures that require staff members to complete screenings for physical, mental health, substance abuse and suicide risk screening for all clients after determining CINS/FINS eligibility. The

agency requires that staff document findings on various client service delivery forms (admission, medical, mental health, shift review, pass down, medication, and progress notes). All staff members in direct and continuous care of youth will be trained in detecting signs and conditions and responding to the need for emergency care and treatment accordingly. Staff are required to place alerts in a centralized binder system that contains a summary sheet on the status of each youth in the shelter. Staff are required to place all current alerts on this sheet. This binder is maintained in the youth care worker office. It is part of the pass down or shift review process that each staff member must review prior and post each work shift.

The reviewer of this indicator assessed a total of five (5) randomly selected client files to test the agency's adherence to the medical and mental health alert process. All 5 client files were active client files of children currently in the youth shelter. Following the screening identification process for any past or current medical, mental health, or allergies, each of the five clients were placed on the program's alert system. There was documented evidence that each of the 5 client files had a medical or mental health condition or allergy that was properly identified through the agency's alert screening process.

The alert system includes a method to identify the client's condition in each file. The alert system includes basic precautions for staff to be aware of related 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.

This reviewer interviewed with three (3) direct care staff and found that staff were informed and 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 client'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.

There were no exceptions documented for this performance indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy called episodic – emergency care. The policy was developed by the Arnette House program to ensure that the client's medical and dental needs are being met when youth are entered into the program. The policy was last reviewed and approved by the agency's chief executive officer on October 21, 2016.

The agency records indicate that they have a written procedure to ensure that emergency medical and dental care include obtaining outside emergency services when required. Procedures also include that parents are notified when a resident 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 resident 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 resident.

The agency has an episodic and emergency care process that is required to be filed by all direct care worker staff members. The agency documents any outside emergency medical or dental care that is experienced by a resident admitted to the program. The agency has an incident reporting process and submit it to the DJJ CCC for any medical or dental care. At the time of this review, the reviewer assessed a total of three (3) incidents involving residents that were in the program. Of these residents, all 3 residents received outside emergency medical care. All 3 had incidents that were submitted to the DJJ CCC on time once the agency gained knowledge and confirmed that the resident was determined to need off-site

medical care.

Two out of 3 said incidents has documented evidence and verification of a receipt of medical clearance and discharge instructions with necessary follow-up and each of the 3 client filed episodic emergency incidents. The agency has evidence that they notified the parent and/or guardian on all 3 said incidents. The agency does have and maintains a daily log on each incident when a youth receives medical services. The agency provides training on emergency and disaster training including first aid, CPR and universal precautions. The agency has emergency procedures that involve emergency equipment such as a knife for life and wire cutters. The agency has first aid kits and supplies. The agency maintains first aid kits in the kitchen, school house, Brannon center and in three transportation vans.

The agency had a total of 3 medical related incident events that were called into the DJJ CCC and accepted. The first event involved a youth that was suffering from ear pain that occurred on the July 6, 2017. This youth was transported by his Grandmother to the Hospital, assessed and released. The second incident involved a youth that was Baker Acted and taken to the hospital by a staff person on July 27, 2017. This youth was transported to the MRMC, assessed and released. The third youth was transported to the local clinic with a case of abdominal pain. This youth did receive outside medical treatment and was returned to shelter.

Exception:

One of the three aforementioned incidents did not have evidence of discharge paperwork verifying receipt of medical clearance with accompanying follow up and referral instructions.