Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Arnette House - Ocala
Residential Program

February 26-27, 2020

Compliance Monitoring Services Provided by

Quality Improvement Review

Arnette House – February 26-27, 2020
Lead Reviewer: Ashley Davies

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

Indicator	Rating
2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity/ Expression	Satisfactory
2.09 Special Populations	Satisfactory
2.10 Stop Now and Plan (SNAP)	Satisfactory

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health /Health Services

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

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

Overall Rating Summary

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

Rating Definitions

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

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

Reviewer

Members

Ashley Davies - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services

Mike Marino – Regional Monitor - Department of Juvenile Justice

Tara Gilligan – Regional Monitor - Department of Juvenile Justice

Sherri Swann – Clinical Supervisor - Luther Services Florida/NW

Cayse Houston – Program Manager - YFA RAP House

Quality Improvement Review

Arnette House – February 26 – 27, 2020
Lead Reviewer: Ashley Davies

Methodology

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

Persons Interviewed

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

Documents Reviewed

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

Surveys

5 # Youth
5 # Direct Care Staff
0 # Other: _____

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

Rating Narrative

Since the last review the shelter had a Threat Assessment completed by a retired Sheriff. One suggestion made was to put a protective film on the windows and door. This film holds the glass together if it is broken so it does not shatter.

The kitchen was painted.

A game room was made in the schoolhouse. All games were donated.

The pool is up and running. The program has implemented pool time into the behavior management system as an incentive to do well in the program.

A private foundation has funded a vocational program at the shelter. The kids do electrical, home maintenance, and plumbing. They have built a small camper, sheds, and are currently building a tiki bar. All items the kids build are auctioned off or donated.

The former Independent Living Program is now the Stop Now and Plan (SNAP) House. It is used for SNAP sessions and dinners.

Standard 1: Management Accountability

Overview

The Arnette House youth shelter is managed by a Chief Executive Officer (CEO) and Chief Operating Officer (COO). The COO oversees one senior team leader and three other team leaders who operate the shelter. The COO and senior team leader oversee the day to day operations of the shelter. At the time of the review the shelter was fully staffed.

Since the last review, the shelter has finished the on-site pool. The pool is surrounded by a chain link fence with an alarm on the gate. All staff have been lifeguard trained. The use of the pool has been worked into the shelters Behavior Management System as an incentive for the youth to do well in the program.
The program collects and reviews data from various sources on a monthly basis. All incidents, accidents, grievances, outcome data, NetMIS data reports, and customer satisfaction data is discussed monthly at the PQI meeting with all department heads, at the all-staff meeting, and also at the Board of Directors meeting. Case record reviews are conducted every Friday by the Clinical Supervisor. The program has one person, the Intake Coordinator, that is responsible for inputting all data into JJIS and NetMIS.

All indicators in standard one were rated satisfactory with exceptions noted in 1.01 Background Screening Requirements and 1.04 Training Requirements. The exception noted in 1.01 was due to a pre-employment suitability assessment not found for a newly hired direct care staff. The exceptions noted in 1.04 was due to one staff receiving three trainings outside the 120-day required time frame and another staff receiving one training outside the 120-day time frame. All other indicators in standard one were rated satisfactory with no exceptions.

Standard 2: Intervention and Case Management

Overview

Arnette House provides residential and non-residential counseling and case management services over two counties, Lake and Marion, across Circuit 5.

The Clinical Supervisor, who is a Licensed Mental Health Counselor (LMHC), oversees both programs. The residential counseling program consists of two counselors. The non-residential program consists of two counselors funded by the FNYFS and three counselors funded by a United Way Grant. The non-residential counselors have offices on-site. The agency also operates a Stop Now and Plan (SNAP) program at this site. The SNAP program is staffed with two case managers and two group facilitators. At the time of the review one of the group facilitator positions was vacant. The SNAP program is housed on-site in a separate building.

The program has only provided domestic violence and probation respite services in the last year. The program has not had any examples of Domestic Minor Sex Trafficking or Family and Youth Respite Aftercare Services (FYRAC) youth in the last year. This site also does not provide Intensive Case Management Services. The program is currently maintaining paper files.

All indicators in standard two were rated satisfactory with exceptions noted in indicators 2.01 Screening and Intake and 2.10 Stop Now and Plan (SNAP). The exceptions noted in 2.01 were due to three out of ten files containing Client Consent forms not filled out in their entirety. Exceptions noted in 2.10 were due to three out of eight files reviewed did not have the pre-Teacher Report Form (TRF) completed in the file or reasons why it could not be completed. Two out of eight files reviewed did not have documentation of the TOPSE being completed at intake or reasons why it could not be completed, and one out of four closed files did not document the post-TRF was completed in the file or reasons why it could not be completed. All other indicators in standard two were rated satisfactory with no exceptions.

Copyright (c) Forefront Revised Aug 2019

Standard 3: Shelter Care

Overview

Arnette House residential program is led by a COO/Shelter Program Manager and a senior team leader who oversee three additional team leaders and nine full-time and two part-time direct care workers. The shelter runs three shifts. At the time of the review, there were no vacant positions.

Other than the addition of the outdoor swimming pool, there were no other major upgrades or physical changes to the shelter. The agency did not have any new vehicles at the time of the review.

The shelter follows a daily schedule that allows time for school, homework, reading, meals, recreation, and sleeping. The schedule is posted in all common areas throughout the shelter.

The program has an effective Behavioral Management Strategy (BMS). It is explained to the youth during program orientation. The BMS includes a wide variety of incentives and appropriate interventions to teach youth new behaviors and help youth understand the natural consequences for their actions. Consequences for violations of program rules are applied logically and consistently. The program uses a variety of rewards/incentives to encourage participation and completion of the program.

Arnette House is licensed by the Department of Children and families for thirty beds. The agency serves both CINS/FINS and DCF program participants. At the time of the review the shelter had seven CINS/FINS youth.

All indicators in standard three were rated satisfactory with exceptions noted in indicators 3.01 Shelter Environment and 3.04 Log Books. The exception noted in 3.01 was due to chemicals being inventoried approximately every two weeks instead of weekly as required by the program's policy. The exception noted in 3.04 was due to errors in the logbooks not always being documented appropriately. All other indicators in standard three were rated satisfactory with no exceptions.

Standard 4: Mental Health/Health Services

Overview

The residential counseling services in the shelter are overseen by the Clinical Supervisor who is a Licensed Mental Health Counselor (LMHC). Services are provided by two, master's level, residential counselors. In addition, the program's Chief Executive Officer is also a LMHC, in case the Clinical Supervisor is not available.

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

Health services are overseen by a part-time registered nurse (RN). The RN is on-site two to three days per week mostly during morning hours. The RN will distribute all medications when on-site and trained youth care workers will distribute medications when the RN is not on-site. The RN provides various trainings for staff, including Medication Administration. All staff are CPR and first aid certified.

All medications in the facility are stored in the Pyxis Med-Station 4000 Medication Cabinet. The RN completes a weekly inventory of all medications on-site. Youth care workers complete shift-to-shift inventories of all controlled medications and maintain perpetual inventories of all other medications. Over-the-counter medications are inventoried at least two to three times per week and when given.

All indicators in standard four were rated satisfactory with exceptions noted in 4.02 Suicide Prevention and 4.03 Medications. The exceptions noted in 4.02 were due to observation times being written over on one youth's observation sheet and three entries on another observation sheet that a staff member initialed one entry then drew an arrow down for the next three entries instead of initialing each entry. The exception noted in 4.03 was due to no documentation that staff had received Epi-Pen training. All other indicators in standard four were rated satisfactory with no exceptions.

Arnette House – February 26-27, 2020
Lead Reviewer: Ashley Davies

STANDARD 1: MANAGEMENT ACCOUNTABILITY

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard One – Management Accountability							
1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						☒ YES ☐ NO (explain) The agency has a policy in place to address the requirements of the indicator titled Background Screening. The policy was last reviewed on July 22, 2019 by the chief executive officer.	No exceptions
RATING	☐	☒	☐	☐	☐	Eleven new hires and three employees requiring a five-year rescreening were reviewed for background screening. An initial background screening was completed prior to hire for all eleven newly hired employees. A request for five-year rescreening was submitted well in advance of the five-year finger print retention date for each of the three employees requiring a five-year rescreen and the re-screenings were completed. Pre-employment assessments were completed for all but one of the newly hired direct care staff. The program uses an internal form for the pre-employment assessment, and each assessment completed was scored.	Exception: A pre-employment assessment was not found for one newly hired direct care staff.

FLORIDA NETWORK of youth and family services

Quality Improvement Review

Arnette House – February 26-27, 2020
Lead Reviewer: Ashley Davies

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						The program submitted an Annual Affidavit of Compliance with Level 2 Screening Standards to the Department's Background Screening Unit on January 27, 2020.	
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						☒ YES ☐ NO (explain) Multiple agency policies and procedures and the employee handbook address provision of an abuse free environment, which include policies titled Abuse Reporting, Supervision (Client) and Staff Conduct, and Grievance – Youth and Families. The policies were last reviewed on July 22, 2019 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	Interviews completed with five youth and five staff indicated staff adhere to the code of conduct and maintain an abuse free environment. All five staff stated they had received training on abuse reporting. None of the staff reported ever seeing a youth being denied the right to report abuse. All five youth reported they feel safe at the program and that staff are respectful to youth. Each youth knew they could report suspected abuse to the Florida Abuse Hotline. All five youth said they had never heard staff use profanity or threaten youth. All youth reported they are not denied food, clothing, or other essential rights. There have not been any	No exceptions.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						instances of staff violating the code of conduct related to treatment of youth requiring management intervention. Grievance forms are available to youth in the large group/dining room. Youth reported they had been informed of the grievance process and that they could talk to staff if they had a problem. The program maintains a grievance binder, which has tabs for each month to maintain grievances for a year. There have been no grievances filed by youth during the review period.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						☒ YES ☐ NO (explain) The agency has a policy and procedure to address the requirements of the indicator titled Incident Report – Client. The policy was last reviewed on July 22, 2019 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The program had four incident reports. The program notified the Department's CCC (Central Communication Center) within two hours of each incident occurring, or of the program learning of the incident. The program completed follow-up communication tasks/special instructions as required by the CCC. All four incidents are documented in the program logs and on incident reporting forms. All four incident reports were	No Exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						reviewed and signed by the Chief Executive Officer.	
1.04: Training Requirements **Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						☒ YES ☐ NO (explain) The agency has two policies in place to address training requirements titled Training and Staff Development and Mandatory Training. The policies were last reviewed on July 22, 2019 by the chief executive officer.	No exceptions
RATING	☐	☒	☐	☐	☐	There were three staff training files reviewed for first year training requirements. The first staff documented 115.25 hours of training for the first year of employment and all required trainings were completed. However, there were three trainings required during the first 120 days of employment that were completed late, CPR, First Aid, and Universal Precautions. The second staff documented 106.5 hours of training with four months left to receive additional hours. This staff has completed all required trainings. The third staff documented 93 hours of training for the first year of employment with approximately one month left to receive additional hours. This staff has received all required training. However, there was one training that was required during the first 120 days of employment that was	Exception: One staff received three trainings outside the 120-day required time frame. Another staff received one training outside the 120-day time frame.

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						completed late, Managing Aggressive Behavior. There were six staff training files reviewed for annual training requirements. All six staff documented more than the required forty hours of training for the 2019 training cycle. All six staff completed all required trainings. An individual training file is maintained for each staff that contains an annual training hours tracking form, certificates, and sign-in sheets for each training attended.	
1.05: Analyzing and Reporting Information **The program collects and reviews several sources of information to identify patterns and trends. Program should have sample reports of aggregated data and committee/workgroup minutes analyzing information.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						☒ YES ☐ NO (explain) The agency has two policies in place to address the requirements of this indicator titled Data Analyzing and Data Collections. The policies were last reviewed on July 22, 2019 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	Case record reviews are conducted every Friday by the Clinical Supervisor. The results of these reviews are then discussed with each counselor individually during their weekly supervision and discussed monthly with all counselors at the monthly clinical meeting.	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Rating: Explain: Deficiency Identified	Rating: Explain: No Eligible Items For Review	Rating: Explain: No Practice	Rating: Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation. Summarize Findings Based on Completed Worksheets	Notes: Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						All incidents, accidents, grievances, outcome data, NetMIS data reports, and customer satisfaction data is discussed monthly at the PQI meeting with all department heads, at the all staff meeting, and also at the Board of Directors meeting. Meeting minutes from all three meetings for the last three months confirmed this practice. During these meetings any strengths and weaknesses are identified, improvements are implemented, and staff are informed and involved. The program has one person, the Intake Coordinator, that is responsible for inputting all data into JJIS and NetMIS. This ensures data is entered timely and correctly. The Intake Coordinator uses monthly reports distributed by the Florida Network to review the accuracy of data entered. Any corrections needed are made at that time.	
1.06: Client Transportation **Policy is established to avoid situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						☒ YES ☐ NO (explain) The agency has a policy and procedure to address the requirements of the indicator titled Transport (Non-Medical). The policy was last reviewed on July 22, 2019 by the chief executive officer.	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Rating Explain: Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
RATING	☒	☐	☐	☐	☐	Vehicle binders and program logbooks were reviewed for transportation. The binders documented each transport, identifying the date and time of the transport, the driver, number of youth, destination, and mileage for the vehicle. Each transport was also documented in the program logbook. There were four instances of one staff transporting a single youth. Supervisory approval for the transport was documented with an entry in the program logbook prior to the transport taking place in all four instances. Staff are not hired unless they are eligible to transport youth under the agency's insurance. Motor vehicle checks are completed on all staff prior to hire and the insurance company is notified of any traffic violations by staff after hire.	
1.07: Outreach Services **The agency participates in local DJJ board and council meetings to increase public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services and ensure CINS/FINS services are represented in a coordinated approach.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						☒ YES ☐ NO (explain) The agency has a policy in place tiled Outreach Services to address the requirements of this indicator. The policy was last reviewed on July 22, 2019 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The agency provided meeting minutes and sign-in sheets for the Circuit 5 Advisory Board Meetings. A	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						representative from the agency has attended these meetings monthly for the last six months. Meeting minutes and sign-in sheets were also provided for the Marion Regional Juvenile Detention Center Advisory Board meetings. A representative from the agency attended these meetings in July, October, and November 2019. The agency has Interagency Agreements with numerous community partners in the areas of prevention, medical, educational, clinical, and recreational. The agreements were all up-to-date and included services provided. The agency has conducted thirty-seven outreach activities in the last six months at local schools, community meetings, and community events. In addition to these outreach activities the agency also promoted program services while in local schools for their SNAP in School sessions.	

STANDARD 2: INTERVENTION AND CASE MANAGEMENT

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard Two – Intervention and Case Management							
2.01: Screening and Intake							
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						☒ YES ☐ NO (explain) The agency has a policy in place tiled Centralized Intake to address the requirements of this indicator. The policy was last reviewed on July 22, 2019 by the chief executive officer.	No exceptions
RATING	☐	☒	☐	☐	☐	There were ten files reviewed, five residential (three open and two closed) and five non-residential (three open and two closed). All ten files had an eligibility screening within seven calendar days of the referral. Six were completed the same day as the referral. Client consent forms, completed at intake include boxes/bullets to be checked when the parent receives the Parent Brochure, info on available service options and explanation of Rights and Responsibilities. Seven of the files reviewed included the required signatures and boxes checked. Two of the ten files did not have the boxes	Exceptions: Three of the files reviewed did not meet all requirements so it was unclear if all screening and intake protocol was considered per requirements. Two of the ten files did not have the boxes marked and one file had the boxes checked but the form was not signed.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						marked and one file had the boxes checked but the form was not signed.	
2.02: Needs Assessment							
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						☒ YES ☐ NO (explain) The agency has a policy in place titled Needs Assessment to address the requirements of this indicator. The policy was last reviewed on July 22, 2019 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were ten files reviewed, five residential (three open and two closed) and five non-residential (three open and two closed). The program utilizes the Child Functional Assessment Rating Scale (CFARS) for their Needs Assessment. It is completed at intake and discharge. Residential files contain an additional Needs Assessment, and a Client Self-Assessment to capture more details of the client's history. Both residential and non-residential utilize the CINS/FINS Intake Form to assess for suicide risk. All counselors completing the assessments were bachelor's or master's level counselors and were signed off by a licensed supervisor.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						The five non-residential files reviewed contained the CFARS and were completed the same day as the intake. None of these clients were identified with an elevated risk of suicide. The five residential files included the CFARs, as well as the additional Needs Assessment and the Client Self-Assessment. Two were identified with an elevated risk of suicide and were assessed by a licensed mental health professional in the required time frame.	
2.03 Case/Service Plan							
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						☒ YES ☐ NO (explain) The agency has a policy in place tiled Case/Service Plans to address the requirements of this indicator. The policy was last reviewed on July 22, 2019 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were ten files reviewed, five residential (three open and two closed) and five non-residential (three open and two closed). The program utilizes a Case Plan form that includes all the required elements, including service type, frequency and location, as well as persons responsible, target dates, completion dates, and signatures for client, parent, and supervisor.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						It is the program practice to develop Case Plans at intake, based on referral needs. All the plans reviewed were found to be individualized and included all the required elements. Two non-residential files did not have client signatures, due to the clients being absent from school on the days for signatures and two residential files did not have parent signatures. In both cases, efforts to acquire signatures were noted. The Case Plans all included dates of initiation. Four of the five non-residential files included thirty-day Case Plan Reviews. The remaining file is just now due for a thirty-day review. None of the residential files were applicable for a thirty-day review.	
2.04: Case Management and Service Delivery							
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						☒ YES ☐ NO (explain) The agency has a policy in place tiled Case Management and Service Delivery to address the requirements of this indicator. The policy was last reviewed on July 22, 2019 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were ten files reviewed, five residential (three open and two closed) and five non-residential (three open and two closed).	No exceptions

	Rating						
Quality Improvement Indicators	Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						All cases had a counselor assigned and documented coordination of services based on referral needs. The progress notes support these efforts. No shows and client absences were also documented. Two non-residential files included a referral to the Case Staffing Committee. Due to client progress, only one client actually attended the committee meeting. Only two residential files were due for a thirty-day follow-up and both were completed in a timely manner. Only one non-residential file was due for a thirty-day follow-up and it was also completed in a timely manner.	
2.05: Counseling Services							
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						☒ YES ☐ NO (explain) The agency has a policy in place tiled Counseling Services to address the requirements of this indicator. The policy was last reviewed on July 22, 2019 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were ten files reviewed, five residential (three open and two closed) and five non-residential (three open and two closed). All files reviewed included documentation supporting coordination between presenting problems and the services	No exceptions

	Rating						
		Explain					
Quality Improvement Indicators	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						provided, including case planning, case management, and progress notes. All files included the required supervisor signatures. Interviews with the counselors indicate regular weekly individual supervision and monthly group supervision and case staffing. The residential counselor and the Direct Care Supervisor explained individual counseling is provided at least once each week but is often more frequent based on client requests. Family Counseling is offered prior to discharge however, according to the residential Counselor, typically families decline this service. According to the Direct Care Supervisor, group counseling is provided Monday – Friday, in the morning for the home school clients and again in the afternoon so the other clients can participate. The program offers a variety of modalities including the *Why Try* curriculum. Groups last between thirty minutes and an hour. The Group Therapeutic/Education Notebook was reviewed for a period of three months (November 2019 –January 2020) to verify group is consistently conducted five days a week. The records	

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						document date, time and a list of participants, as well as indication of what the activity included. Additional groups are conducted in the morning and at night to discuss house updates, schedules, and client issues and/or concerns.	
2.06: Adjudication/Petition Process							
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						☒ YES ☐ NO (explain) The agency has two policies in place titled Adjudication Services and CINS Petition Process to address the requirements of this indicator. The policies were last reviewed on July 22, 2019 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	Three files were reviewed for this indicator, two open and one closed. Interviews with two of the non-residential counselors and the Clinical Supervisor indicated a regular schedule for Case Staffing Committee Meetings. In Lake County the meetings are held on the last Thursday of every month and in Marion County, they meet on Wednesdays. In Lake County the meetings are a bit smaller but include the required school and DJJ representatives. In Marion County, the committee is well attended and supported by a much broader	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						community representation, including law enforcement, DCF and others who may be involved with the youth. The program maintains documentation of Committee Meetings in a separate binder, as well as in the client files. Documentation includes notification to the committee and the parents within five days of the meeting as well as a recording of the recommendations made by the committee. The documentation includes a checkbox to acknowledge the parent was given a copy of the recommendations at the close of the meeting. Two of the cases reviewed were initiated by the parent and happened to coincide with the day of the Case Staffing Committee meeting so the parents were notified immediately.	
2.07: Youth Records							
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						☒ YES ☐ NO (explain) The agency has a policy in place tiled Confidentiality of Client Information to address the requirements of this indicator. The policy was last reviewed on July 22, 2019 by the chief executive officer.	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
RATING	☒	☐	☐	☐	☐	All ten files reviewed were marked confidential and were maintained in a neat and orderly manner. files are kept in a locked room, in locked file cabinets. The Intake Coordinator has the key to the file room. An extra key is kept locked in the Pyxis med cart for access when the Intake Coordinator is out. When being transported, files are secured in opaque locked boxes, marked confidential. This reviewer witnessed the boxes in use. While the file room and cabinets were locked and marked confidential.	No exceptions
2.08: Sexual Orientation, Gender Identity, Gender Expression							
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						☒ YES ☐ NO (explain) The agency has a policy in place to address the requirements of this indicator titled Sexual Orientation, Gender Identity, and Gender Expression. The policy was last reviewed on July 22, 2019 by the Chief Executive Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The agency has copies of the Zine located in the shelter lobby for all staff, visitors, and volunteers to take and read if needed. The SOGIE policy is also located in the front of the visitor and volunteer sign-in binder for all visitors and volunteers to review upon entering the shelter.	No exceptions

	Rating						
Quality Improvement Indicators		Explain				**Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation** **Summarize Findings Based on Completed Worksheets**	**Notes** **Explain Exception, Failed, or Not Applicable Indicators:** **(Attach Supportive Documentation)**
	Satisfactory	**Deficiency Identified**	**No Eligible Items For Review**	**No Practice**	**Not Applicable**		
						There is signage located throughout the shelter, in all common areas, indicating the program is a safe place for all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression. Signage includes signs of rainbows and statements written in rainbow colors. The agency has had one youth in the last six months that was a female youth who identified as a male youth. This youth was able to sleep on the male dorm as requested and was able to dress in clothing that affirmed his gender identity. The youth was addressed by his preferred name and gender pronoun. The youth's preferred name and pronoun were used on all outward facing documents.	
2.09: Special Populations							
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						☒ YES ☐ NO (explain) The agency has a policy in place to address the requirements of this indicator titled Special Population. The policy was last reviewed on July 22, 2019 by the Chief Executive Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The shelter has not had any Staff Secure, Domestic Minor Sex Trafficking, or Family and Youth Respite Aftercare Services (FYRAC) since the last on-site Quality Improvement review. The agency also	No exceptions

	Rating						
Quality Improvement Indicators		Explain				Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						does not provide Intensive Case Management services. There were three Domestic Violence (DV) Respite files reviewed. All three youth had a pending DV charge and did not meet the criteria for secure detention. All three youth had data entered into NetMIS and JJIS within 24 hours of admission and 72 hours of discharge. None of the youth stayed in the shelter beyond 21 days. All three Case Plans reflected goals focusing on aggression management, family coping skills, and other interventions designed to reduce the reoccurrence of violence in the home. All other services provided to the youth was consistent with all other general CINS/FINS program requirements. There were three Probation Respite files reviewed. All three referrals came from DJJ Probation. All three youth were referred on probation regardless of adjudication status. All three youth had data entered into NetMIS and JJIS within 24 hours of admission. The one applicable closed file documented data was entered within 72 hours of discharge. The other two files were open files. None of the youth had a length of stay more than 14 to 30 days. All three files had documentation that all case management and counseling needs were considered and addressed. All other services provided to the youth	

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						was consistent with all other general CINS/FINS program requirements.	
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						☒ YES ☐ NO (explain) The agency has five policies in place to address the requirements of the indicator titled SNAP Intake Requirements, SNAP in Schools, SNAP Group Delivery, SNAP Fidelity Adherence Monitoring, and SNAP Discharge Requirements. The policies were last reviewed on July 22, 2019 by the Chief Executive Officer.	No exceptions
RATING	☐	☒	☐	☐	☐	There were eight SNAP clinical group files reviewed, four open and four closed. All eight files documented the NETMIS screening form and the SNAP Brief Intake Screening form were completed on admission. In seven of the eight files there was a consent form signed by the parent prior to the youth receiving services. In the eighth file the form was not signed; however, the youth and parent have not started the clinical groups yet. In all eight files the Needs Assessment was initiated at intake.	Exceptions: Three out of eight files reviewed did not have the pre-Teacher Report Form (TRF) completed in the file or reasons why it could not be completed. Two out of eight files reviewed did not have documentation of the TOPSE being completed at intake or reasons why it could not be completed. One out of four closed files did not document the post-TRF was completed in the file or reasons why it could not be completed.

Copyright (c) Forefront Revised Aug 2019

	Rating						
		Explain					
Quality Improvement Indicators	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	**Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation** **Summarize Findings Based on Completed Worksheets**	**Notes** **Explain Exception, Failed, or Not Applicable Indicators:** **(Attach Supportive Documentation)**
						In seven of the files a Pre-Child Behavior Checklist (CBCL) was completed at intake. In the eighth file the Pre-CBCL was not completed. The counselor reported it was left with the parent during the intake and it was not returned. Out of the eight files three had the Pre-Teacher Report Form (TRF) completed in the file. Two of the remaining files documented the form was sent to the teacher; however, was not completed. The remaining three files did not have the Pre-TRF completed in the file and did not have documentation of it being sent to the teacher. The counselor did report the form was sent just not documented in the notes. In six of the eight files the TOPSE assessment was completed at intake and located in the file. In the remaining two files the assessment was not in the file and there was no documentation as to why it could not be completed. All eight files documented the PAT assessment was completed at intake. Out of the four applicable closed files two documented the Post-CBCL was completed at discharge. The remaining two files documented the youth dropped out of the program and the post-	

	Rating						
		Explain					
Quality Improvement Indicators	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						assessment forms could not be completed. Out of the four applicable closed files one documented the Post-TRF was completed and in the file. One file did not have the form completed and did not document the form being given to the teacher. The counselor reported the form was given to the teacher but not documented in the notes. The remaining two files documented the youth dropped out of the program and the post-assessment forms could not be completed. Out of the four applicable closed files two documented the Post-TOPSE was completed at discharge. The remaining two files documented the youth dropped out of the program and the post-assessment forms could not be completed. Out of the four applicable closed files two documented the PAT assessment was completed at discharge. The remaining two files documented the youth dropped out of the program and the post-assessment forms could not be completed. All four closed files documented a SNAP Discharge Report Summary was completed.	

	Rating						
		Explain				Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
Quality Improvement Indicators	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						There were three completed SNAP in Schools sessions reviewed. All three documented weekly attendance sheets for all thirteen weeks, signed by the teacher and facilitator. All three documented the Class Shoot for Your Goal sheet was completed. All three sessions documented pre and post evaluations were completed for most of the youth. The counselor reported some of the times the youth would choose not to complete the form. All three sessions documented pre and post evaluations were completed for each teacher. All three sessions documented one Fidelity Adherence Checklist was completed for each classroom for the 13-week session cycle.	

STANDARD 3: SHELTER CARE

Quality Improvement Indicators	Rating: Satisfactory	Rating – Explain: Deficiency Identified	Rating – Explain: No Eligible Items For Review	Rating – Explain: No Practice	Rating – Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
Standard Three – Shelter Care							
3.01 Shelter Environment **The shelter's environment is safe, clean, neat and well maintained. The program provides structured daily programming to engage youth in activities that foster health, social, emotional, intellectual and physical development.**							
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						☒ YES ☐ NO (explain) The agency has a policy in place tiled Shelter Program Services to address the requirements of this indicator. The policy was last reviewed on July 22, 2019 by the chief executive officer.	No exceptions
RATING	☐	☒	☐	☐	☐	A facility tour was conducted. The shelter showed no signs of insect infestation, furnishings are in good repair, grounds are landscaped and well maintained, bathrooms and showers are clean and functional, there is no graffiti on walls, doors or windows, lighting is adequate for tasks performed in all observed areas. Exterior areas are free of debris, grounds are free of hazards, the dumpster is covered, and all doors are secure. The agency has three vehicles. Two agency vehicles were available for observation. One vehicle was out for repairs. Of the two agency vehicles observed, both were equipped with major safety equipment including a first aid kit,	Exception: Per agency policy, all chemicals are to be inventoried a minimum of one time per week. However, the chemical inventory logbook shows that chemicals are inventoried approximately every two weeks.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						fire extinguisher, flashlight, glass breaker, seat belt cutter and air bag deflator. In and out access is limited to staff members and key control is in compliance. A detailed map and egress plans of the facility are located at exit doors in each building. Grievance forms, abuse hotline information, DJJ Incident Reporting number and other related notices are posted throughout the facility. The agency has a current DCF Child Care License which is displayed in the facility. The effective license date is January 13, 2020. Interior areas do not contain contraband and are free from hazardous, unauthorized objects. All chemicals are listed in the chemical inventory binder, approved for use, and stored securely. The Material Safety Data Sheet was missing for CBI Bleach. Staff corrected the error on site. The facility has three washers and three dryers. All six machines were in operation at the time of the review. Each youth has his/her own individual bed with a clean covered mattress, pillow, sufficient linens and a blanket. All youth	

Quality Improvement Review

Arnette House – February 26-27, 2020
Lead Reviewer: Ashley Davies

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						are provided a locker to keep personal belongings. Annual facility fire inspections were conducted, and the facility is in compliance with local fire marshal and fire safety code. The agency completes a minimum of one fire drill per month within two minutes or less. Logs show that fire drills are completed on each shift, each month. All annual fire safety equipment inspections are valid and up to date. The agency has a current Satisfactory Residential Group Care Inspection report and a current Satisfactory Food Service inspection report from the Department of Health. Food menus are posted, current and signed by a Licensed Dietician. All cold food is properly stored, marked and labeled and the dry storage area is clean, and food is properly stored. The refrigerator and freezer are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed. Youth are engaged in meaningful, structured activities seven days a week during awake hours. Idle time is minimal. At least one hour of physical activity is provided daily. Youth are provided the opportunity to participate in a variety of	

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. A daily programming schedule is publicly posted and accessible to both staff and youth.	
3.02: Program Orientation							
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						☒ YES ☐ NO (explain) The agency has a policy in place tiled Program Orientation to address the requirements of this indicator. The policy was last reviewed on July 22, 2019 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	A review of three open and two closed youth records show all five youth received a comprehensive orientation and handbook provided within 24 hours of admission which explained disciplinary action, grievance procedure, emergency/disaster procedures, contraband rules, and room assignment. All five youth were provided a facility tour. Two open youth records were applicable to Suicide Prevention – Alert Notifications. The program has a separate file that records all youth alerts, which is	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						accessible to all staff. Both youths had a suicide alert recorded. In all five records, parent and youth signatures were obtained, daily activities were reviewed, and the Abuse Hotline number was provided on the Arnette House Youth and Family Services form that was signed by the youth and parent/guardian.	
3.03: Youth Room Assignment							
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						☒ YES ☐ NO (explain) The agency has a policy in place tiled Room and Bed Assignments to address the requirements of this indicator. The policy was last reviewed on July 22, 2019 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	A review of three open and two closed records show all five youth were provided an initial classification that includes a review of the youth's history, status and exposure to trauma, age, gender, history of violence, disabilities, physical size, gang affiliation, suicide risk, sexually aggressive or reactive behaviors and gender identification. In all five records, initial interactions and observations were reviewed. Two youth were applicable for alerts. The program has a separate file that records all youth alerts, which is accessible to all	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						staff. Both youths had all relevant alerts recorded in the file.	
3.04: Log Books							
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						☒ YES ☐ NO (explain) The agency has a policy in place tiled Logbooks to address the requirements of this indicator. The policy was last reviewed on July 22, 2019 by the chief executive officer.	No exceptions
RATING	☐	☒	☐	☐	☐	Logbooks contained a color code on the front page, and notes indicating safety and security issues that could impact the youth and/or program were highlighted with the corresponding color. Entries were brief and legibly written and included dates and times, names of youth and staff, and the signature of the person making the entry. No white out was seen in the logbooks. Supervisory staff reviewed the logbooks at the beginning of each shift for the previous shifts. Direct care staff review the logbooks at the beginning of each shift, which is evidenced by the date and their signature at time of entry. The program director or designee reviews the facility logbook every week and makes a note chronologically indicating dates reviewed and if any correction, recommendations and follow-up is required, which is	Exception: In general, logbook errors are being struck through with a clear line with staff initials, however, there were a few exceptions where errors were scribbled out or an X was placed over the error instead of a line strike with initials.

Quality Improvement Indicators	Rating: Satisfactory	Rating (Explain): Deficiency Identified	Rating (Explain): No Eligible Items For Review	Rating (Explain): No Practice	Rating (Explain): Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation. Summarize Findings Based on Completed Worksheets	Notes. Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						evidenced by the date and their signature at time of entry. Supervision and resident counts are documented. There was no indication that any home visits were conducted within the review period.	
3.05: Behavior Management Strategies							
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						☒ YES ☐ NO (explain) The agency has a policy in place tiled Behavior Management Strategy to address the requirements of this indicator. The policy was last reviewed on July 22, 2019 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The program has a detailed written description of the Behavioral Management Strategy (BMS) and it is explained during program orientation. The written description of the BMS include a wide variety of incentives and appropriate interventions to teach youth new behaviors and help youth understand the natural consequences for their actions. Consequences for violations of program rules are applied logically and consistently. The program uses a variety of rewards/incentives to encourage participation and completion of the program. All staff are trained in the theory and practice of administering the BMS rewards and consequences. Supervisors are trained to monitor the use of	No Exceptions

Quality Improvement Indicators	Rating: Satisfactory	Rating: Explain: Deficiency Identified	Rating: Explain: No Eligible Items For Review	Rating: Explain: No Practice	Rating: Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						behavioral interventions by their staff to include the use of point-based and level-based intervention. There is a protocol for providing feedback and evaluation of staff regarding their use of the positive and negative consequences. In general, BMS promotes order, safety, security, respect, fairness and protection of the resident's rights, and provides for positive reinforcement and recognition; constructive dialogue and peaceful resolution and minimizes separation of youth from the general population. Disciplinary measures do not deny the youth regular meals and snacks, clothing, sleep, physical or mental health services, educational services, exercise, correspondence privileges, or contact with parents/guardians, the attorney of record, juvenile probation officer, or clergy.	
3.06: Staffing and Youth Supervision							
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						☒ YES ☐ NO (explain) The agency has two in place to address the requirements of the indicator, titled Staffing and Youth Supervision, and Supervision (Client) and Staff Conduct. The policies were last reviewed on July 22, 2019 by the chief executive officer.	No exceptions

Quality Improvement Review

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
RATING	☒	☐	☐	☐	☐	Observations during the review found the required staff-to-youth ratios were maintained. Staff actively supervised youth and maintained good positioning in order to be able to observe all youth. Staff schedules were reviewed for the past three months. The schedules showed staff coverage to meet the required daytime ratio of one staff for every six youth and nighttime ratio of one staff for every twelve youth. Logbooks were reviewed for the same period, which confirmed staff on duty. There were always at least two staff on during the night shift. The schedule reflected at least one male staff and at least one female staff on each shift. There was only one night in which there was not a male staff, and this was due to the male staff who was on duty going home sick (there were still two female staff). The staff schedule is posted and there is a holdover rotation to ensure coverage. Logbooks documented youth were checked every fifteen minutes when in their rooms. A review of video for three different nights confirmed staff completed checks of youth in their rooms every fifteen minutes.	No exceptions.
3.07: Video Surveillance System							

FLORIDA NETWORK of youth and family services

Quality Improvement Review

Arnette House – February 26-27, 2020
Lead Reviewer: Ashley Davies

Quality Improvement Indicators	Rating: Satisfactory	Rating – Explain: Deficiency Identified	Rating – Explain: No Eligible Items For Review	Rating – Explain: No Practice	Rating – Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						☒ YES ☐ NO (explain) The agency has a policy in place tiled Video Surveillance System to address the requirements of this indicator. The policy was last reviewed on July 22, 2019 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The program's camera system includes twenty-five cameras and has a recording capability of thirty days. The system reflects the date, time, and location (by camera) during playback of video. The system has facial recognition capabilities. The program has a generator, which automatically turns on in the event of a power outage and cameras continue to operate. There is camera coverage for almost all program common areas, to include interior and exterior areas. There are no cameras placed in sleeping rooms or bathrooms. Only designated staff can access the camera system, and there is a list of the staff with access posted in the staff station. Supervisory reviews of video were documented bi-weekly over the past six months. The program is able to record video to a disk if requested or needed for quality improvement or investigative purposes.	No exceptions

STANDARD 4: MENTAL HEALTH/HEALTH SERVICES

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard Four – Mental Health /Health Services							
4.01: Healthcare Admission Screening							
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						☒ **YES** ☐ **NO (explain)** The agency has a policy in place tiled Health Screening on Admission to address the requirements of this indicator. The policy was last reviewed on July 22, 2019 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were six residential youth files reviewed, two closed and four open. All six files reviewed had the youth's Healthcare Screening completed the same day of their intake. All six files reviewed had observation for presences of scars, tattoos, or other skin markings. All six files reviewed had observation for evidence of illness, injury, pain or physical distress, difficulty moving, etc. Two out of the six youth reviewed were on medications at the time of intake, which were documented on the Healthcare Screening. None of the six youth reviewed were documented having any medical	No exceptions

Copyright (c) Forefront Revised Aug 2018

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation. Summarize Findings Based on Completed Worksheets	Notes. Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						conditions on the Healthcare Screening. None of the six youth reviewed were documented having any allergies on the Healthcare Screening. None of the six youth reviewed were documented having any recent injuries or illnesses on the Healthcare Screening. None of the six youth reviewed were documented having any presence of pain or other physical distress on the Healthcare Screening. None of the six youth reviewed were documented having any of the following medical conditions on the Healthcare Screening: diabetes, pregnancy, seizure disorder, cardiac arrest, asthma, tuberculosis, hemophilia, or head injuries in the last 2 weeks. None of the six youth reviewed required coordination and/or scheduling of medical appointments.	
4.02 Suicide Prevention **There is a written plan that details the program's suicide prevention and response procedures. The plan complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.**							
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						☒ **YES** ☐ **NO (explain)** The agency has a policy in place tiled Suicide Protocol to address the requirements of this indicator. The policy was last reviewed on July 22, 2019 by the chief executive officer.	No exceptions
RATING	☐	☒	☐	☐	☐	The agency is utilizing a suicide risk assessment that was been approved by the Florida Network of Youth and Family	Exception: On one youth's observation sheet, times were documented as one time, and then

	Rating						
		Explain					
Quality Improvement Indicators	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						Services. There were six residential youth files reviewed, two closed and four open. All six files reviewed had documentation of the suicide risk screening completed with the youth during the initial intake and screening process. Of the six youth files reviewed, three youth were placed on sight-and-sound supervision until assessed by a licensed professional or non-licensed professional under the direct supervision of a licensed professional. All three youth who were placed on sight-and-sound supervision were assessed by a licensed professional or non-licensed professional under the direct supervision of a licensed professional within twenty-four hours from the suicide risk assessment. All three youth were placed on the appropriate level of supervision based on the results of the suicide risk assessment. Supervision levels were not changed for any of the three youth on sight-and-sound supervision until they were assessed by a licensed professional or non-licensed professional under the direct supervision of a licensed professional. Staff assigned to monitor youth documented the youths' behaviors every thirty minutes or less which include the	written a new time over top of the original time. There were three entries on another observation sheet that a staff member initialed one entry then drew an arrow down for the next three entries instead of initialing each entry.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						time of day, behavioral observations, warning signs observed, and the observer's initials.	
4.03: Medication							
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						☒ **YES** ☐ **NO (explain)** The agency has a policy in place tiled Medication Distribution for Non-Healthcare Staff to address the requirements of this indicator. The policy was last reviewed on July 22, 2019 by the chief executive officer.	No exceptions
RATING	☐	☒	☐	☐	☐	All medications are stored in a Pyxis Med Station, which is inaccessible to the youth, including narcotics and controlled medications. Oral medications stored separately from injectable epi-pens and topical medications. Medications requiring refrigeration are stored in a secure refrigerator that is only used for medications. The temperature for the refrigerator was viewed at 40 degrees F. The agency maintains three Super Users for the Pyxis Med Station. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances. Shift-to-shift counts are conducted and documented for controlled substances with a second staff as a witness. A perpetual	Exception: The agency stated they do complete training on epi-pens with staff verbally and through a video; however, there is no documentation provided to show training was completed.

Quality Improvement Indicators	Rating: Satisfactory	Rating (Explain): Deficiency Identified	Rating (Explain): No Eligible Items For Review	Rating (Explain): No Practice	Rating (Explain): Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation. Summarize Findings Based on Completed Worksheets	Notes. Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						inventory with running balances are maintained for controlled substances. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory. Syringes and sharps are secured and documentation of them being counted at least weekly. Medication discrepancies are cleared after each shift. There are monthly reviews of medication management practice completed by the agency nurse. The agency has a policy in place that states the program does not accept youth that are currently prescribed injectable medications, except for epi-pens. A medication distribution log is used for the distribution of medication by non-licensed and licensed staff. The agency verifies medications timely by calling the pharmacy that filled the prescriptions. When the program nurse is on duty, the medication processes are conducted by her. The delivery process of medication is consistent with the FNYFS policy.	
4.04: Medical/Mental Health Alert Process							
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						☒ **YES** ☐ **NO (explain)** The agency has a policy in place tiled Mental Health and Substance Abuse Screening and Alert to address the requirements of this indicator. The policy	No exceptions

FLORIDA NETWORK of youth and family services

Arnette House – February 26-27, 2020
Lead Reviewer: Ashley Davies

Quality Improvement Review

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						was last reviewed on July 22, 2019 by the chief executive officer.	
RATING	☒	☐	☐	☐	☐	There were six residential youth files reviewed, two closed and four open. All six youth had alerts documented on the daily logs, which the staff complete three times a day. There is a detailed process in place to ensure information concerning a youth's medical and/or mental health treatment information is communicated to all staff. The program starts gathering information at intake, the nurse and counselor gather and document supplemental information in their assessments with the youth, and there is the daily log that they pass the information through. Staff are provided sufficient information and instructions to recognize and respond to the need for emergency care for medical and/or mental health problems. The program's practice in place does not match the program's policy titled Mental Health and Substance Abuse Screening and Alert. Per the program's policy the screening information collected will be documented on the Medical and Mental Health Alert Form located in file. The form requires a staff signature at the bottom. The agency stated they have the guardian complete the Medical and Mental Health Alert Form and sign it, not the staff. Therefore, a majority of the alerts	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						identified during the screening process are not documented on this form. The policy also states the program will document an alert on the front of the case record, which was not reflected on the youth files reviewed.	
4.05: Episodic/Emergency Care							
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						☒ **YES** ☐ **NO (explain)** The agency has a policy in place tiled Episodic and Emergency Care to address the requirements of this indicator. The policy was last reviewed on July 22, 2019 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	Two episodic emergency care incidents that required off-site emergency medical care were reported. Both incidents were documented on the program's incident report with all necessary information. In both instances, the guardian was notified and provided the transportation from the program to the medical facility. A daily log is maintained by the agency. All staff are adequately trained on emergency medical procedures. The program has one knife-for-life and wire cutter kit which is located in the Med Station. The program has seven first aid kits and supplies, which are located in the Med Station, three agency vehicles, the	No exceptions

	Rating						
		Explain				Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
Quality Improvement Indicators	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						kitchen, the school building, and the administration building.	

Florida Network for Youth and Family Services
Compliance Monitoring Report for

Arnette House
2310 NE 24th Street
Ocala, FL 34470
Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for Arnette House for the FY 2019-2020 at its program office located at 2310 NE 24th Street, Ocala, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. Arnette House is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 2019 through June 30, 2020.

The review was conducted by Ashley Davies, Consultant for Forefront LLC and Peer Reviewer(s). Agency representatives from Arnette House present for the entrance interview were: Mark Shearon, COO; Jason Kasten, CFO; Cheri Pettitt, CEO; Pamela Washington, Direct Care Supervisor; Theresia Jackson, Clinical Supervisor; and Toshiko Brown, SNAP Facilitator. The last onsite QI visit was conducted December 11 – 12, 2018.

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

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

2019-2020 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 02-26-2020

Agency Name: Arnette House	**Monitor Name: Ashley Davies, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 2310 NE 24th Street, Ocala, FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): February 26 - 27, 2020**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	Interview: The program currently has six staff members certified as DJJ QI Peer reviewers. Five of the staff members have participated as peer reviewers this season.	**No recommendation or Corrective Action.**
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: The agency provided a list of several additional funding sources. The list includes: the awarding entity and contract start and end dates. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. All of the agreements reviewed had current contract/agreement dates.	**No recommendation or Corrective Action.**
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as	☐	☐	☒	☐	☐	Documentation: General Liability through Philadelphia Indemnity Insurance Company, for limits of coverage $1,000,000 each $3,000,000 aggregate and medical	**No recommendation or Corrective Action.**

Agency Name: Arnette House						Monitor Name: Ashley Davies, Lead Reviewer	
Contract Type : CINS/FINS						Region/Office: 2310 NE 24th Street, Ocala, FL	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): February 26 - 27, 2020	
	Explain Rating						
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	**Ratings Based Upon:** I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	**Notes** **Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						expenses of $20,000 for each person; effective 12/01/19 – 12/01/20. Workers Compensation through Associated Industries Insurance Company, Inc. with limits of $1,000,000 each/aggregate, effective 02/28/20 – 2/28/21. Automobile insurance through Philadelphia Indemnity Insurance Company for combined single limit of $1,000,000 each accident and uninsured motorist of $1,000,000. Policy effective for 12/01/19 – 12/01/20. Florida Network is listed on the Worker's Compensation certificate as certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	**N/A –** During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	**No recommendation or Corrective Action.**
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are maintained on the hard drive of the CFO's computer. The procedures reviewed appear to be consistent with	**No recommendation or Corrective Action.**

Agency Name: Arnette House						Monitor Name: Ashley Davies, Lead Reviewer	
Contract Type : CINS/FINS						Region/Office: 2310 NE 24th Street, Ocala, FL	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): February 26 - 27, 2020	
Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	**Notes** Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**						GAAP and provide for sound internal controls. Procedures are included for cash flow management, financial planning, accounting, bank accounts, payroll, petty cash, record retention, and other relevant financial processes.	
b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: Detailed General Ledger for the current FY 2019-2020 with detail through January 2020 Agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS program.	**No recommendation or Corrective Action.**
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Documentation and Observation: The fund does not exceed $200 was reconciled onsite. Petty cash is stored in a locked box in the Administrative Assistants office. The fund was successfully reconciled with cash on hand. The documentation of all receipt totals was provided. The CFO reported all receipts are submitted to him for reimbursement once a month. The CFO makes out a check and cashes it and the cash is then placed in the petty cash box.	**No recommendation or Corrective Action.**

Agency Name: Arnette House						Monitor Name: Ashley Davies, Lead Reviewer	
Contract Type : CINS/FINS						Region/Office: 2310 NE 24th Street, Ocala, FL	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): February 26 - 27, 2020	
	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	**Notes** Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation and Observation: Reviewed Bank Statements and Bank Reconciliations for the past six months. Financial Statements are reported on a monthly basis and were found to be current. Bank reconciliations are conducted each month for the activities and bank statements for the preceding month. A tracking form is printed out from Quick Books that documents all spending for the month and that form is then compared to bank statements. All reconciliations were signed off on by the CFO and CEO. Invoices are submitted on a monthly basis with supporting documentation. The agency maintains individual vendor files.	**No recommendation or Corrective Action.**
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	**No recommendation or Corrective Action.**
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), <u>Employee</u> IRS Form W-2 and <u>Independent Contractors</u> IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Documentation provided to show 2019 payroll taxes were paid per month by the agency. Documentation was	**No recommendation or Corrective Action.**

Agency Name: Arnette House						Monitor Name: Ashley Davies, Lead Reviewer	
Contract Type : CINS/FINS						Region/Office: 2310 NE 24th Street, Ocala, FL	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): February 26 - 27, 2020	
Major Programmatic Requirements	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						provided that showed payments from January 2019 to December 2019. The agency contracts with ADP to pay payroll taxes. There was documentation ADP paid the payroll taxes from January 2019 to present. Documentation of 941's was provided for the last two quarters.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided a Profit and Loss statement, as of January 2020, that tracks budgeted, actual, and % difference for all income sources. Variances in budget are monitored on a monthly basis, by the CFO, with all members of management during the monthly management meetings. The CFO has created a very detailed tracking form, which tracks all income sources with variances in what was budgeted each month, it also documents the reasons for the variance and what is being done to change it.	**No recommendation or Corrective Action.**
h. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2019 and 2018 was completed. A separate Management Letter requiring a Corrective Action Plan was not issued by the auditor. A	**No recommendation or Corrective Action.**

Agency Name: Arnette House						Monitor Name: Ashley Davies, Lead Reviewer	
Contract Type : CINS/FINS						Region/Office: 2310 NE 24th Street, Ocala, FL	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): February 26 - 27, 2020	
Major Programmatic Requirements	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**						copy of the audit was submitted to the FNYFS.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Policies and procedures for Confidentiality/Release of Information, System Backup, and Disaster Recovery were reviewed. A daily back-up is performed on all information saved on various servers throughout the agency.	**No recommendation or Corrective Action.**

CONCLUSION

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

SUMMARY OF RECOMMENDATIONS

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

If required, the provider must submit a corrective action plan to address corrective actions cited in the corresponding section of this report. The provider's Corrective Action Plan should address the issues, corrective actions item cited, time frames and staff responsible. Responses to items cited for corrective actions are due to the Florida Network and the Florida Network Contract Manager within fourteen (14) working days of receipt of this report (See Florida Network Site for the Service Provider Corrective Action Form). The Florida Network Contract Manager will then review the response to the corrective action(s) to determine if the response adequately addresses the problem identified in the report within three (3) days. Upon approval the provider will then implement the approved measure to address the item(s) cited in the report. If the corrective action is successful in resolving the items cited in the report the contract monitor will notify the Provider in writing that the desired resolution has been achieved. Log on to the Florida Network (www.floridanetwork.org) website forms section and download the Service Provider Corrective Action Tracking Form.