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 2020-2021 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 2020 through June 30, 2021.

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; Cheri Pettitt, CEO; Pamela Washington, Direct Care Supervisor; Theresia Jackson, Clinical Supervisor; and Toshiko Brown, SNAP Facilitator. The last onsite QI visit was conducted February 26 – 27, 2020.

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

2020-2021 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 05-05-2021

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): May 5-6, 2021

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)
	Explain Rating						
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 four staff members certified as DJJ QI Peer reviewers. Two 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.**

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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 12/01/20 – 12/01/21. Workers Compensation through Associated Industries Insurance Company, Inc. with limits of $1,000,000 each/aggregate, effective 02/28/21 – 2/28/22. 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 12/01/20 – 12/01/21. 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.**

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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. Policies had a review date of 4/27/2021 by the CEO.	
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: The agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS program. The general ledger was provided for the current fiscal year from July 2020 – April 2021.	**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 and 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.**

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	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, from October 2020 – March 2021, for one account with TD Bank. 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 review.	**No recommendation or Corrective Action.**
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form	☐	☐	☒	☐	☐	Documentation: Documentation provided to show payroll taxes were paid per month by	**No recommendation or Corrective Action.**

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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)**
W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**						the agency. Documentation was provided that showed payments from the last two quarters. The agency contracts with ADP to pay payroll taxes. 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 March 2021, 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 $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2020 and 2019 was completed by Purvis Gray. A separate Management Letter requiring a Corrective Action Plan was not issued by the auditor. A copy of the audit was submitted to the FNYFS.	**No recommendation or Corrective Action.**

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from 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, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited and no recommendation is made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

SUMMARY OF RECOMMENDATIONS

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

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Arnette House - Ocala
CINS/FINS Program

May 5 – 6, 2021

Compliance Monitoring Services Provided by

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 85.71%
Percent of indicators rated Limited: 14.29%
Percent of indicators rated Failed: 0.00%

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health /Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 96.55%
Percent of indicators rated Limited: 3.45%
Percent of indicators rated Failed: 0.00%

Rating Definitions

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

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

Reviewer

Members

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

Jennifer Schad – Regional Monitor, Department of Juvenile Justice

Patricia Fleurant – Orange County Family Counseling Services

Tara Shook – Youth and Family Alternatives

Laura Saldana – Lutheran Services Florida

Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, and (3) Shelter Care/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2020/Jan 2021).

Persons Interviewed

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

Documents Reviewed

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

Observations During Review

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

Comments

Due to COVID-19, this review was conducted **hybrid (virtually and on-site)**.

Monitoring Purpose:

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

Strengths and Innovative Approaches

Since the last review, the program received a grant and was able to install new recreational equipment.

The youth in the program recently built a tiny house and the house is being donated to a veterans organization to house a homeless veteran.

The program has trained four more lifeguards so they will be able to use to swimming pool on-site more over the summer months.

At the time of the review, the program was working on a grant to re-do the dayroom of the facility.

The Shelter Supervisor has been using Stop Now and Plan (SNAP) techniques on youth in the shelter and is working on using the parent techniques with the staff.

Narrative Summary

Standard 1

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 had one full-time and two part-time Direct Care Worker positions vacant.

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.

Standard 2

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 one Counselor. The non-residential program consists of four Counselors funded by the FNYFS and two 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 three 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.

Standard 3

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 was one full-time and two part-time Direct Care Worker positions vacant.

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 System (BMS). Itis 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 youth. At the time of the review the shelter had five CINS/FINS youth.

Standard 4

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 one, master's level, residential counselor. 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 medications in the facility are stored in the Pyxis Med-Station4000 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.

The overall findings for the QI Review for Arnette House are summarized as follows:

Standard 1: This standard has a total of seven indicators regarding management accountability. Six of the seven indicators were rated satisfactory. Indicator 1.04 Training Requirements was rated limited. The reasonings for this limited rating are listed below. There were exceptions noted in indicator 1.02 Abuse Free Environment and 1.03 Incident Reporting. The exceptions noted in 1.02 were due to one youth who did not indicate whether or not they agreed with the resolution of a grievance filed and did not sign the grievance form after it was resolved. The exception noted in 1.03 was due to two CCC reports that were reported outside the two-hour required time frame. The exceptions in these two indicators did not result in limited ratings.

Standard 2: This standard has a total of ten indicators that relate to intervention and case management. There was an exception noted in indicator 2.09 Special Populations due to there being no documentation two youth on Probation Respite having referrals that were submitted to the Florida Network. This exception did not result in a limited rating. All other indicators in this standard were rated satisfactory with no exceptions.

Standard 3: This standard has a total of seven indicators regarding shelter care. Six of the seven indicators were rated satisfactory with no exceptions noted. There was an exception noted in indicator 3.01 Shelter Environment due to an annual fire inspection not being completed in the last year. The last one completed was December 12, 2019. This exception did not result in a limited rating.

Standard 4: This standard has a total of five indicators regarding mental health and health services. All five indicators were rated satisfactory. There were exceptions noted in indicators 4.02 Suicide Prevention, 4.03 Medications, and 4.05 Episodic/Emergency Care. The exception noted in 4.02 was due to a youth being removed from suicide precautions prior to consulting with a licensed mental health professional. The exception noted in 4.03 was due to one controlled medication not being counted shift-to-shift as required. The exception noted in 4.05 was due to one staff having an expired CPR and First Aid certification. The exceptions noted in these indicators did not result in limited ratings.

Summary of Deficiencies resulting in Limited or Failed Rating:

Standard 1: Indicator 1.04 Training Requirements was rated a limited due one staff not completing the DOJ Civil Rights and Federal Funds training. Also, one staff was missing five trainings required in the first 90 days of employment as well as all required DJJ Skill Pro trainings and another staff completed one required training late. Lastly, one staff had an expired CPR and First Aid certification.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators:	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	Review Based Upon Document Source	Notes
Standard One – Management Accountability							
1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						**YES X NO (explain)** The agency has a policy in place to address the requirements of the indicator titled Background Screening. The policy was last reviewed on February 9, 2021 by the Chief Executive Officer.	
Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation to for staff hired with a non-passing/low score.	X					A total of six new staff were hired since the last QI review. All six the staff met the criteria for a pre-screening assessment. The agency uses the Applicant Risk Profiler. All six staff had an Applicant Risk Profiler completed prior to hire and documented a passing score.	
Background screening completed prior to hire/start date or exemption obtained prior to working with youth (if rated ineligible) for new hires, volunteers/interns, and contractors	X					A total of six new staff were hired since the last QI review. All six staff were background screened prior to hire.	
Five-year re-screening completed every 5 years from initial date of hire	X					There was a total of two staff applicable for a five-year rescreening during this review period. Both staff had a re-screening completed prior to the initial date of hire.	

	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	X					The agency submitted the Annual Affidavit of Compliance with Level 2 Screening via email to the Background Screening Unit on 12/22/2020.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					Documentation of approval of E-Verify work eligibility was provided for all six new staff hired.	
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						**YES X NO (explain)** 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 February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Abuse Free Environment							
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	X					The program maintains a code of conduct which prohibits the use of physical abuse, profanity, threats, or intimidation that all staff must adhere to. This is reviewed with staff at hire.	
Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	X					Child Abuse telephone number was observed during the virtual tour to be posted in the lobby and in the large group/dining room of the shelter.	
Youth were informed of the Abuse and Contact Number (see youth survey results)	X					The Abuse Hotline number was provided on the Arnette House Youth and Family Services form that was signed by the youth and parent/guardian in all five shelter files reviewed.	
Management takes immediate action to address any incidents of threats or abuse			X			The program reported there were no incidents of abuse or threats identified and/or reported during the review period needing management action.	
Grievance Process							
Agency has a formal grievance process	X					A review of the program's policy confirmed the agency has a formal grievance process in place.	
Locked box accessible to only management and available to youth in a common area	X					During the virtual tour it was observed that the program has an accessible grievance box that is locked and located in the large group/dining room. The	

						supervisor has a key to the box, and it is checked daily.	
Direct care does not handle the complaint/grievance unless assistance is asked for by the youth. Program director/supervisor will have access to and manage grievances unless it is towards themselves.	X					The program's policy for grievance procedures states direct care staff will not handle grievances. All grievances reviewed were signed and resolved by a supervisor. Only the supervisors have a key to the grievance box.	
72-hour resolution requirement by management. If this does NOT occur within the 72 hour period, there is sufficient documentation explaining the cause for the delay in resolution.		X				There was one grievance filed in the last six months. The grievance was addressed, an investigation was completed, and an interview with youth and other youth in the shelter was completed. The result of this investigation and interviews were thoroughly documented on the grievance form. This was all completed the same day the grievance was filed by the youth.	**Exception:** The youth did not indicate whether or not they agreed with the resolution and did not sign the grievance form after it was resolved.
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						**YES X NO (explain)** The agency has a policy to address the requirements of the indicator titled Incident Report –Client. The policy was last reviewed on February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident		X				There were nineteen incidents reported to the CCC during the last six months. Six of the reports were related to a staff or youth testing positive for Covid-19. Out of the remaining thirteen reports eleven were reported to the CCC within two hours of the program learning of the incident.	**Exception:** Two incidents were reported to the CCC outside of the two-hour time frame.
The program completes follow-up communication tasks/special instructions as required by the CCC	X					All thirteen reports documented follow-up communication and tasks were completed as required and the reports were successfully closed.	
Incidents are documented in the program logs and on incident reporting forms	X					All thirteen reports were documented in the programs logbook and also documented on incident reporting forms.	

All incident reports are reviewed and signed by program supervisors/directors	X					All incident reports reviewed were signed by the person completing the report and by a supervisor.	
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						**YES X NO (explain)** The agency has two policies in place to address training requirements titled Training and Staff Development and Mandatory Training. The policies were last reviewed on February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
First Year Direct Care Staff							
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. *(Staff hired before January 1st were required to complete no later than December 31, 2020)*		X				There were nine staff training files reviewed. Eight of the nine staff completed the DOJ Civil Rights and Federal Funds training in the required time frames.	**Exception:** One newly hired staff had been with the program longer than 30 days and still had not completed the DOJ Civil Rights and Federal Funds training.
All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				There were four staff training files reviewed for first year training requirements. Two of the four staff completed all required trainings in the first 90 days of hire.	**Exception:** One staff was missing five trainings required in the first 90 days as well as all required DJJ Skill Pro trainings. Another staff completed one required training late.

All staff completes all mandatory Florida Network and SkillPro training during the first-year employment.		X				There were four staff training files reviewed for first year training requirements. One of the three staff had completed all first-year training requirements. The other three staff still had time remaining in their first year of employment to receive all required trainings.	**Exception:** One staff did not complete any DJJ Skill Pro trainings in the required time frame.
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training			X			There were no non-licensed clinical staff requiring this training during this review period.	
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).			X			There were no non-licensed clinical staff requiring this training during this review period.	
In-Service Direct Care Staff							
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*		X				There were five staff training files reviewed for in-service training requirements. All five staff files documented more than the required 40 hours of annual training and four of the five staff documented all required trainings for their last completed training cycle.	**Exception:** One staff had an expired CPR and First Aid certification.
Required Training Documentation							
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.	X					All nine training files reviewed contained a spreadsheet documenting all trainings, date completed, and hours. Also, training files included any related documentation such as training certificates, sign-in sheets, and training worksheets.	

Quality Improvement Review

Arnette House – May 5-6, 2021
Lead Reviewer: Ashley Davies

Provider has a written policy and procedure that meets the requirement for Indicator 1.05						**YES X 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 February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	X					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.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	X					All incidents, accidents, and grievances, are discussed monthly at the PQI meeting with all department heads, at the all-staff meeting, and also at the Board of Directors meeting.	
The program conducts an annual review of customer satisfaction data	X					All 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.	
The program conducts an annual review of outcome data and (if applicable) there is evidence of annual reconciliation that occurs through communication from the Florida Network via email or phone call when corrections are needed and the information is corrected and submitted within the requested timeframes.	X					All outcome 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. The program reported they had completed their annual reconciliation with the Florida Network and all corrections were made.	
The program conducts a monthly review of NetMIS data reports.	X					All NetMIS data reports are discussed monthly at the PQI meeting with all department heads, at the all-staff meeting, and also at the Board of Directors meeting.	
The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that they have reconciled any differences noted.	X					The 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.	
The program has a process in place to review and improve	X					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	

accuracy of data entry & collection						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.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**X**					All findings are shared and reviewed with management and staff during the monthly PQI meetings and monthly staff meetings. Findings are shared and reviewed with stakeholders during the monthly Board of Directors meetings. Meeting minutes reviewed from all three of these meetings confirmed this practice.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**X**					Any improvements or corrective actions needed are implemented when the issues are discussed at the monthly meetings. Meeting minutes also confirmed that strengths and weaknesses are identified.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES X 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 February 9, 2021 by the Chief Executive Officer.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**X**					The program provided a list of staff approved to transport youth.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**X**					There was documentation all drivers had a valid Florida driver's license and are covered under the agency's insurance policy. 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.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**X**					The programs policy titled Transport (Non-Medical) prohibits transporting a youth without another passenger in the vehicle. There are provisions in place in case a 3rd party is not present in the vehicle.	

In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	X					A review of vehicle logs for the last six months documented all single client transports had a supervisor's approval obtained prior to the transport taking place. Approval was documented in the program log book.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					The 3rd party present on transports reviewed for the last six months was either an agency staff member or another youth.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	X					The vehicle logs document each transport, identifying the date and time of the transport, the driver, number of youth, destination, and mileage for the vehicle.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						**YES X NO (explain)** The agency has a policy in place tiled Outreach Services to address the requirements of this indicator. The policy was last reviewed on February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
The program has a lead staff member designated to participate in local DJJ board and council meetings with evidence that includes minutes of the event or other verification of staff participation	X					The program provided emails with meeting agendas and Zoom meeting link for the Circuit 5 Advisory Board Meetings. A representative from the agency has attended the last six meetings held which were in September 2020, November 2020, January 2021, February 2021, March 2021, and April 2021. Due to Covid-19 all these meetings were held virtually via Zoom.	
Outreach and prevention services are provided by designated staff and include increasing community awareness, offering informational and educational CINS/FINS services to youth and families.	X					The program provided a report of outreach activities in the last six months at local schools, community meetings, and community events. In addition to these outreach activities the program also promoted program services while in local schools for their SNAP in School sessions.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	X					The program 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.	

FLORIDA NETWORK of youth and family services

Quality Improvement Review

Arnette House – May 5-6, 2021
Lead Reviewer: Ashley Davies

Provider has a written policy and procedure that meets the requirement for Indicator 2.01						**YES X NO (explain)** The agency has two policies in place titled Screenings and Intake to address the requirements of this indicator. The policies were last reviewed on February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Shelter youth: Eligibility screening is completed immediately for all shelter placement inquiries. If staff on duty cannot complete the screening, an on-call supervisor is contacted and eligibility is determined within 30 minutes from initial inquiry.	**X**					There were five shelter files reviewed, one open and four closed. All five files documented an eligibility screening was completed immediately.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the NetMIS form	**X**					There were five community counseling files reviewed, three open and two closed. All five files documented an eligibility screening was completed within three days of the referral.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**X**					All ten files documented the youth and parent/guardian received, in writing, available services options, rights and responsibilities, and brochure.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**X**					All ten files documented the youth and parent/guardian were provided information on possible actions occurring through involvement with CINS/FINS services and the grievance procedure.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						**YES X NO (explain)** The agency has a policy in place titled Assessment to address the requirements of this indicator. The policy was last reviewed on February 9, 2021 by the Chief Executive Officer.	

FLORIDA NETWORK of youth and family services

Quality Improvement Review

Arnette House – May 5-6, 2021
Lead Reviewer: Ashley Davies

Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Completion of Needs Assessment							
Shelter Youth: Needs Assessment initiated within 72 hours of admission	X					There were five shelter files reviewed, one open and four closed. All five files documented the Needs Assessment was initiated within 72 hours of admission.	
Non-Residential youth: Needs Assessment is done within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	X					There were five community counseling files reviewed, three open and two closed. All five files documented the Needs Assessment was completed within two to three face-to-face contacts.	
Needs Assessment is conducted by a bachelor's or master's level staff member	X					All ten Needs Assessments were completed by a bachelor's or master's level staff member.	
Needs Assessment includes a supervisor's review signature upon completion	X					All ten Needs Assessments were signed by a supervisor upon completion.	
Suicide Risk as a Result of the Needs Assessment							
Youth was identified with an elevated risk of suicide as a result of the Needs Assessment			X			None of the files reviewed documented the youth identified with an elevated risk of suicide as a result of the Needs Assessment.	
If yes, the youth was referred for an Assessment of Suicide Risk conducted by or under the direct supervision of a licensed mental health professional			X			None of the files reviewed documented the youth identified with an elevated risk of suicide as a result of the Needs Assessment.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES X NO (explain)** The agency has four policies in place tiled Case assignment and Caseload, Case Notes, Case Plan, and Case Plan Review to address the requirements of this indicator. The policies were last reviewed on February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Case/Service plan is developed within 7 working days of Needs Assessment	X					There were ten files reviewed, five shelter files reviewed, one open and four closed, and five community counseling files, three open and two closed. All ten files had a Service Plan developed within seven working days of the Needs Assessment.	

Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the Needs Assessment 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	X					All ten Service Plans reviewed included individualized and prioritized needs and goals identified by the Needs Assessment, service type, frequency and location, persons responsible, and target dates for completion. Of the ten files reviewed, six files include actual goal completion dates while one shelter file and three community counseling files are still open. All ten Service Plans had the signature of the counselor, supervisor, youth, and parent.	
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	X					One shelter file and all five community counseling files were applicable for 30 day reviews. All of the 30 day reviews in these files were completed as required. The remaining four shelter files reviewed were not applicable for 30 day reviews due to not being in the program long enough.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						**YES X NO (explain)** The agency has four policies in place tiled Case assignment and Caseload, Case Notes, Case Plan, and Case Plan Review to address the requirements of this indicator. The policies were last reviewed on February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Counselor/Case Manager is assigned	X					There were ten files reviewed, five shelter files, one open and four closed, and five community counseling files, three open and two closed. All ten files had a counselor assigned.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation	X					All ten files establish referral needs and coordinated referrals to services based upon the ongoing assessment of the youth's/family's problems and needs, coordinated service plan implementation, monitored youth's/family's progress in service, and provided support to families. Six out of ten files were applicable and documented monitoring out-of-home placement. None of the files were applicable for referring the youth and family to the case staffing committee. None of the files were applicable for	

3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitors out-of-home placement (if necessary) 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit						accompanying youth/guardian to court hearings and related appointments. All ten files were applicable and referred the youth/family for additional services. All ten files provided case monitoring and reviews. All six applicable files provided case termination documentation. There were two files applicable for providing follow-up after 30 days of exit and one file after 60 days of exit. All follow-ups were completed as required.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	X					The program has Interagency Agreements with numerous community partners in the areas of prevention, medical, educational, clinical, and recreational. The agreements were all up-to-date, included services provided, and allowed for a comprehensive referral process.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						**YES X NO (explain)** The agency has two policies in place tiled Counseling Services and Case Supervision to address the requirements of this indicator. The policies were last reviewed on February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Youth and families receive counseling services, in accordance with the youth's case/service plan, to address needs identified during the assessment process	X					There were ten files reviewed, five shelter files, one open and four closed, and five community counseling files, three open and two closed. Service plans and case notes maintained demonstrated all ten youth received counseling services to address needs identified during the assessment process.	
Shelter Program							

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

						treatment paperwork in each file to ensure staff performance is adequate.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						**YES X NO (explain)** The agency has two policies in place titled Adjudication Services and CINS Petition Process to address the requirements of this indicator. The policies were last reviewed on February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Case Staffing Initiation and Notifications							
If parent/guardian initiates, staffing is held within 7 days	X					There were three case staffings reviewed. One of the staffings was initiated by the parent and it was held within seven days.	
The youth, family and case staffing committee are contacted within a minimum of five working days a. Notification to youth/family no less than 5 working days prior to staffing b. Notification to committee no less than 5 working days prior to staffing	X					All three case staffings documented the family and committee were notified at least five working days prior to the staffing.	
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	X					All three staffings included the CINS/FINS provider and a school representative.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	X					Staffings' documented other members were present as needed or requested.	
The program has an established case staffing committee, and has	X					The program has an established committee that meets on a regular basis. In Lake County the meetings are	

regular communication with committee members						held on the last Thursday of every month and in Marion County, they meet on Wednesdays.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	X					The program has two policies in place titled Adjudication Services and CINS Petition Process to address case staffing procedures and has a committee that meets on a regular basis.	
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services	X					In all three case staffing's the youth and family were provided a revised plan for services.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	X					In all three cases a written report was provided to the parent within seven days of the staffing outlining recommendations and reasons for the recommendations.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family					X	None of the four files reviewed were applicable for judicial intervention.	
Case Manager/Counselor completes a review summary prior to the court hearing					X	None of the four files reviewed were applicable for judicial intervention.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						**YES X NO (explain)** The agency has two policies in place tiled Client Access to Case Records and Client Rights and Privacy to address the requirements of this indicator. The policies were last reviewed on February 9, 2021 by the Chief Executive Officer.	

Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
All records are clearly marked 'confidential'.	X					All ten youth files reviewed were marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	X					All files are kept in a locked room, in locked file cabinets marked confidential. 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 in transport, all records are locked in an opaque container marked "confidential"	X					When being transported, files are secured in opaque locked boxes, marked confidential.	

All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	X					All files were maintained in a consistent manner and were neat and orderly making information easy to access.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						**YES X NO (explain)** The agency has a policy in place to address the requirements of this indicator titled Sexual Orientation, Gender Identity, and Gender Expression. The policy was last reviewed on February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Use of youth's preferred name/ pronoun: a. Youth are addressed according to their preferred name and gender pronouns b. Youth's preferred name and gender pronouns are used in logbook and on all outward-facing documents and census boards			X			A review of the Florida Network's SOGIE Report as of March 8, 2021 does show two youth who were identified as transgender males; however, an interview with COO revealed there have been no youth who have fallen under the requirements of this indicator since the last Quality Improvement review. The two youth identified on the report was a data entry error.	
Youth in need of specialized support is referred to qualified resources (as applicable)			X			A review of the Florida Network's SOGIE Report as of March 8, 2021 and an interview with program staff confirmed there have been no youth who have fallen under the requirements of this indicator since the last Quality Improvement review.	
Youth preference is considered and documented for room assignment and youth is not roomed in isolation due to sexual orientation, gender identity, or gender expression			X			A review of the Florida Network's SOGIE Report as of March 8, 2021 and an interview with program staff confirmed there have been no youth who have fallen under the requirements of this indicator since the last Quality Improvement review.	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression			X			A review of the Florida Network's SOGIE Report as of March 8, 2021 and an interview with program staff confirmed there have been no youth who have fallen under the requirements of this indicator since the last Quality Improvement review.	
The agency has signage and brochures/publication placed in common areas indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression	X					A virtual tour of the facility showed The SOGIE policy is located in the front of the visitor and volunteer sign-in binder for all visitors and volunteers to review upon entering the shelter. There is also 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.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						**YES X NO (explain)** The agency has a policy in place to address the requirements of this indicator titled Special Population. The policy was last reviewed on February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Staff Secure							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO** **X**	**N/A**			The program has not served any youth meeting the criteria for staff secure since the last QI review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**X**					The program's policy titled Special Population covers all requirements for staff secure services.	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services			**X**				
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor			**X**				

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

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

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

days requires the approval of the JPO and/or CPO)							
All case management and counseling needs have been considered and addressed	X					All case management and counseling needs identified were addressed.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	X					The youth received all other general CINS/FINS required services.	
Intensive Case Management (ICM)							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO**		**N/A** **X**		This program does not provide ICM services.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Youth receiving services was court ordered or referred by case staffing committee					X		
Services for youth and family include: a. Four (4) direct contacts per month b. Four (4) collateral contacts per month					X		
Assessments include: a. A Child Behavior Checklist (CBCL) is completed within 14 days of intake and at discharge (if applicable) b. An approved self-report assessment that was completed at intake c. An approved self-report assessment that was completed every 90 days following intake and at discharge (if applicable)					X		

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

b. Includes development of the service plan and is documented through signature of the youth and his/her parent/guardian as well as orientation to the program							
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Individual Sessions are with the youth and family and focus to engage, identify strengths and needs of each member that help to improve family functioning			**X**				
Group Sessions: a. Focus on the same issues as individual/family sessions with the overall goal of strengthening relationships and prevention domestic violence b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session			**X**				
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff			**X**				
2.10: STOP NOW AND PLAN (SNAP)							

Quality Improvement Review

Arnette House – May 5-6, 2021
Lead Reviewer: Ashley Davies

Provider has a written policy and procedure that meets the requirement for Indicator 2.10						**YES X 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 February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
SNAP Clinical Groups							
Youth are screened to determine eligibility of services	X					There were three closed files reviewed. All three files had the NetMIS Screening form and SNAP Brief Intake Screening form.	
Needs assessment is completed at initial intake, or within two face-to-face sessions	X					Needs Assessment was initiated at intake in all three files.	
SNAP Assessments a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post) b. Teacher Report Form (TRF) completed by the teacher (pre & post) c. Tool for Parenting Self Efficacy (TOPSE) completed by the caregiver (pre & post) d. Prevention Assessment Tool (PAT) (pre & post)	X					A pre and post CBCL was completed in all three files. A pre and post TRF was sent to the teacher to complete in all three files. Only one pre TRF was completed and returned. No other TRF's were returned. There were follow-up emails in all three files, to the teachers, to attempt to have the pre and post TRF's completed and returned. A pre and post TOPSE was completed in all three files. A pre and post PAT was completed in all three files.	
SNAP discharge report summary	X					All three files had a SNAP discharge report summary.	
SNAP Boys/SNAP Girls **Parent** Group Evaluation Form	X					All three files had a Parent Group Evaluation Form.	
SNAP Boys/SNAP Girls **Child** Group Evaluation Form	X					All three files had a Child Group Evaluation Form.	
SNAP in Schools							
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		

Weekly attendance sheet with youth names and/or identifying number completed with signatures of teacher and facilitator(s) (For a total of 13 attendance sheets)	X					All 13 weekly attendance sheets were present with youth names and teacher and facilitator signatures.	
"Class Goal" sheet	X					"Class Shoot for Your Goal" sheet was completed.	
Measure of Classroom Environment (MoCE) (Pre and Post) is used to identify baseline and treatment outcomes of reported classroom dynamics.	X					There was a pre and post MoCE completed.	
Pre and Post Evaluations	X					Pre and post evaluations were present for all youth and the teacher.	
One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox	X					There was one Fidelity Adherence Checklist completed during the 13-week group.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES X NO (explain)** The agency has a policy in place tiled Shelter Program Services to address the requirements of this indicator. The policy was last reviewed on February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Facility Inspection	X					A virtual tour of the facility revealed furnishings were in good repair. The program was free of insect infestation. Grounds were landscaped and maintained. Bathrooms were clean and functional. No graffiti was observed. Lighting was adequate. Exterior areas were free of debris and grounds were free of hazards. Dumpster and garbage cans were covered. Doors were secured with key access required. 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 program has three vans used for transporting youth	

						which were equipped with major safety equipment as required. Interior areas of the vans did not contain contraband and were free of hazardous items. Chemicals were stored behind locks and inventories and MSDS were maintained. The program has three washers and three dryers. All washers and dryers were operational and clean of lint. A current DCF license was displayed with an effective date of January 13, 2021. Each youth has their own individual bed with clean, covered mattress, pillow, and sufficient linens. All Youth are provided a locker to keep personal belongings.	
Fire and Safety Health Hazards		X				The annual fire inspection was completed on December 12, 2019. The annual fire sprinkler inspection was February 9, 2021. The annual fire extinguisher inspection was June 10, 2020. The annual fire alarm inspection was September 18, 2020. A review of drills indicated the program conducted on average three fire drills per month. The program also completed mock emergency drills, including at a minimum, one per shift per quarter. Residential Group Care inspection was completed on November 12, 2020, and Food Establishment Inspection was completed on February 15, 2021. The kitchen exhaust inspection was March 17, 2021. Menus were posted and signed by a licensed dietician. Cold food was properly stored, marked, and labeled, and dry storage/pantry areas were clean. Refrigerators/freezers were clean, and temperatures were maintained.	**Exception:** An annual fire inspection has not been completed in the last year. The last one was completed on December 12, 2019.
Youth Engagement							
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a	X					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 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	

variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.						programming schedule is publicly posted and accessible to both staff and youth.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						**YES X NO (explain)** The agency has a policy in place tiled Program Orientation to address the requirements of this indicator. The policy was last reviewed on February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Youth received a comprehensive orientation and handbook provided within 24 hours	X					There were five shelter files reviewed, one open and four closed. All five youth received a comprehensive orientation and provided a handbook within 24 hours of admission.	
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services	X					The orientation process included a review of daily activities, disciplinary actions, grievance procedures, emergency/disaster procedures, contraband rules, dress code, medical and mental health services, procedures for visitation, mail and telephone, and room assignment. All five youth were provided a facility tour.	

e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention-alerting staff of feelings or awareness of others having suicidal thoughts							
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	X					Documents of each component of orientation including orientation topics and the date presented were present in each file. Initials and the signatures of both staff and youth were noted in each file reviewed.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						**YES X NO (explain)** The agency has a policy in place tiled Room and Bed Assignments to address the requirements of this indicator. The policy was last reviewed on February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
A process is in place that includes an initial classification of the youths, to include:							
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth	X					There were five shelter files reviewed, one open and four closed. Each file indicated a process for the youth bed assignment including initial classification of the youth, with consideration given to potential safety and security concerns. The intake form includes a review of youth history, exposure to trauma, age, gender, gender identification, physical stature, disabilities, and history of violence, gang affiliation, sexually aggressive behavior, and suicide risk. Collateral contacts were documented as well as initial interactions and observations of youth.	

f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Sexual orientation gender identity/ expression k. Acute health symptoms requiring quarantine or isolation							
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	X					Three youth were applicable for alerts. The program has a separate file that records all youth alerts, which is accessible to all staff. All three youth had all relevant alerts recorded in the file.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						**YES X NO (explain)** The agency has a policy in place tiled Logbooks to address the requirements of this indicator. The policy was last reviewed on February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Log book entries that could impact the security and safety of the youth and/or program are highlighted	X					Logbook entries were reviewed for November 2-7, 2020, December 13-19, 2020, January 16-23, 2021, February 1-6, 2021, March 7-13, 2021, and April 15-22, 2021. Entries that impacted the safety and security of the youth or program were observed to be highlighted.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity	X					All entries were brief and legible, included the date and time of the event, included names of youth and staff involved, provided a brief statement, and included	

• Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry						the name and signature of the person making the entry.	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**X**					Any errors were corrected properly with one line drawn and marked with initials.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	**X**					The COO/Shelter Manager reported the Shelter Supervisor is the designee to review the logbook. The Shelter Supervisor reviews the logbook daily instead of weekly. A review of the logbook entries listed above confirmed the Shelter Supervisor reviewed the logbook daily and noted any corrective actions or follow-up required.	
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	**X**					Direct care staff are reviewing the log for the previous two shifts at the start of their shift and make an entry into the logbook indicating dates reviewed.	
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	**X**					Supervisors and counselors are reviewing the logbook of all shifts since their last log entry to become aware of any unusual occurrences, problems, etc. They sign and date the logbook indicating the dates reviewed.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**X**					Supervision and youth counts were documented clearly at the beginning of each shift. Visitation and home visits were documented.	

Provider has a written policy and procedure that meets the requirement for Indicator 3.05						**YES X NO (explain)** The agency has a policy in place tiled Behavior Management System to address the requirements of this indicator. The policy was last reviewed on February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
The program has a detailed written description of the BMS, and it is explained during program orientation	X					The youth are provided a copy of the behavior management system at intake. A review of five shelter files confirmed this practice.	
Behavior Management Strategies MUST include: a. Supervisors are trained BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ	X					The behavior management system that the program uses is the Point System. This system allows the youth to make choices in what and how they will perform their daily task and accept the natural consequences that come from making poor choices. Peer Leaders are chosen and assigned four to five youth to work with depending on the census to help youth make better choices. The program operates on the principle that rather than judging youth by an outside set of regulations with predetermined consequences, program structure can be maintained by allowing youth to assess their own behaviors and decide the natural consequences of these behaviors. It is designed to allow the youth to explore his or her behavior and draw conclusions for a better resolution. The Point System provides rewards, privileges, and consequences. Rewards come in the form of a sense of personal accomplishment for each youth, verbal praise from peers and staff, and visual concrete reminders of each youth's achievement and the opportunity to shop in the point store. The RAPS problem solving process is used to determine the natural consequences of actions, rather than staff administering punitive consequences.	

are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges							
Program's Use of the BMS							
All staff are trained in the theory and practice of administering BMS rewards and consequences	X					All staff are trained on the Point System during the time of hire. A review of four newly hired staff training files confirmed this practice.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	X					All staff receive supervision regarding their implementation of the system both individually and during staff meetings.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	X					Supervisors are trained to monitor the use of 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.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES X NO (explain)** The agency has a policy in place tiled Staffing and Youth Supervision to address the requirements of this indicator. The policy was last reviewed on February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		

The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	X					There were five random samples of video surveillance reviewed, April 9, 2021 from 12am - 1am, April 14, 2021 from 2am - 3am, April 18, 2021 from 4am - 5am, April 24, 2021 from 1am - 2am, and April 29, 2021 from 3am – 4am. A review of the above video surveillance sample, staff schedules, and log book entries documented required staffing ratios were met for awake hours and sleeping hours.	
All shifts must always provide a minimum of two staff present	X					The review included the random sample above, log book entries, and staff schedules reviewed for the last six months documented at least two staff were present on all shifts.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	X					All staff that were included in staff-to-youth ratios had an eligible background screening completed and had been appropriately trained.	
The staff schedule is provided to staff or posted in a place visible to staff	X					During the virtual tour, the schedule was observed posted in the staff office area.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	X					The program maintains a phone listing of staff who may be available when coverage is needed. There is also a holdover rotation in place to ensure coverage.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	X					A review of the video surveillance system for the five random samples listed above showed consistent fifteen-minute checks by staff. The log book also confirmed staff were constantly observing the youth every fifteen minutes.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						**YES X NO (explain)** The agency has a policy in place tiled Video Surveillance System to address the requirements of this indicator. The policy was last reviewed on February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Surveillance System							

The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	X					The cameras and written notices were observed during the virtual tour. System can capture and retain video images for up to thirty days. A review of random samples of overnight video surveillance revealed system records date, time, and location, and enables facial recognition. The program has a generator, which automatically turns on in the event of a power outage and the cameras will continue to operate. All cameras were visible, and no cameras were located in the bathrooms or sleeping rooms.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	X					The programs maintains a list of staff who can access the video surveillance system. The list consisted of supervisory staff and is posted in the staff office area.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook. The reviews assess the activities of the facility and include a review of random sample of overnight shifts	X					Supervisory reviews were conducted at least every 14 days for the last 6 months and documented in the log book. The reviews included a random sample of overnight shifts and assessed the activities of the facility and included any corrections needed.	

Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	X					The program has procedures in place in policy titled Video Surveillance System to handle requests of video recordings within 24 – 72 hours.	
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	X					The program has procedures in place in policy titled Video Surveillance System to ensure service orders are made within 24 hours of discovery and includes documentation requirements.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						**YES X NO (explain)** The agency has a policy in place tiled Health Screening on Admission to address the requirements of this indicator. The policy was last reviewed on February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Preliminary Healthcare Screening							
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	X					There were five shelter files reviewed, one open and four closed. The health screening section of the CINS/FINS Intake Form was completed in all five files and included all required elements. The program had implemented procedures to take the youths temperatures at intake and screen youth for COVID-19 related symptoms. All health screenings were reviewed by a Registered Nurse (RN) within five business days.	
Referral and Follow-up							
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure			X			None of the five youth presented with chronic conditions requiring a referral to ensure medical care.	

disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)							
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments			X			None of the five youth presented with chronic conditions requiring a referral to ensure medical care.	
All medical referrals are documented on a daily log.			X			None of the five youth presented with chronic conditions requiring a referral to ensure medical care.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	X					There are procedures in place to involve the parent in any follow-up medical care or referrals needed.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						**YES X NO (explain)** The agency has a policy in place tiled Suicide Protocol to address the requirements of this indicator. The policy was last reviewed on February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Suicide Risk Screening and Approval							
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	X					There were five shelter files reviewed, one open and four closed. All five files contained a suicide risk screening completed during the initial intake screening process that was signed by a supervisor.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					The program's suicide risk assessment tool was reviewed, and it was reported it had been previously approved by the Florida Network.	
Supervision of Youth with Suicide Risk							
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	X					Three out of the five youth were placed on sight-and-sound supervision until assessed by a mental health professional. A suicide risk assessment was completed within twenty-four hours, and all three youth were removed from suicide precautions based on the results from the assessment.	
Staff person assigned to monitor youth documented youth's	X					In all three files the observation logs documented the youth were monitored at least every thirty minutes while on sight-and-sound supervision.	

behavior at 30 minute or less intervals							
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement		X				In two of three files the youth were removed from sight-and-sound supervision after a suicide risk assessment was completed by or reviewed with the licensed professional.	**Exception:** In the third file the suicide risk assessment was completed on April 12, 2021, by a non-licensed counselor and not signed by the LMHC until April 19, 2021. The youth was removed from suicide precautions on April 12, 2021, and there was no documentation on the suicide risk assessment of a consultation with the LMHC prior to removal.
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES X NO (explain)** The agency has a policy in place tiled Medication Distribution for Non-Healthcare Staff to address the requirements of this indicator. The policy was last reviewed on February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Medication Storage							
a. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management	X					A virtual tour of the Pyxis Med-Station was completed. The Pyxis Med-Station is located in the staff office and is inaccessible to youth. All medications are stored in the Pyxis Med-Station 4000 medication cabinet. Oral medications are stored separately from topical medications in the locked medical cabinet. There is a secure refrigerator used only for medical purposes and maintained at 40 degrees F. All narcotic and controlled medications are stored in the Pyxis Med-Station 4000 medication cabinet.	

c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Med-Station							
Medication Distribution							
a. Agency maintains a minimum of 2 Super Users for the Med-Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed	X					The program 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. A review of three youth files supported they took medication while in the program. All three files contained a Medication Distribution Log (MDL) completed as required. Staff verify medication either by the Registered Nurse (RN) or by calling the pharmacy that filled the prescriptions. The RN distributes all medications when on-site. Trained direct care staff distribute medication when the RN is not on-site. All medication in the three files reviewed was distributed as required. All staff have training in the use of epi-pens by the RN.	

injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse							
Medication Inventory							
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly		X				A perpetual inventory with running balances is maintained for all medications. 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.	**Exception:** During the review it was discovered one medication a youth was taking was a controlled medication; however, the youth's MDL did not document the medication as a controlled substance, so the medication was not counted shift-to-shift as required. All other controlled medications reviewed were counted shift-to-shift with a witness present as required.
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	X					The RN runs weekly and monthly reports via the knowledge portal.	
Medication discrepancies are cleared after each shift.	X					At the time of the review there were no open discrepancies. The RN reported all discrepancies are cleared out at the end of each shift. The RN also runs a weekly discrepancy report via the Knowledge Portal. Staff are aware that discrepancies should be cleared at the end of each shift.	

FLORIDA NETWORK of youth and family services

Quality Improvement Review

Arnette House – May 5-6, 2021
Lead Reviewer: Ashley Davies

Provider has a written policy and procedure that meets the requirement for Indicator 4.04						YES X NO (explain) The agency has a policy in place tiled Medical, Mental Health, and Substance Abuse Screening and Alert to address the requirements of this indicator. The policy was last reviewed on February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	X					There were five shelter files reviewed, one open and four closed. Three of the five files documented the youth had alerts and were placed in the program's alert system.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	X					In the three applicable files reviewed, precautions concerning prescribed medications and medical/mental health conditions were documented on intake and screening forms and on the youth's MDL's.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	X					All staff are provided training on emergency medical care. Staff are also provided information and instructions on how to respond to each individual youth's medical/mental health problems on the youth's screening forms, assessments, and MDL's. In addition, a daily log is completed three times a day, on each shift, and documents all alerts each youth is on.	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	X					Alerts are documented on all intake and screening forms in the youth's file. The alerts are also documented three times a day on the daily log completed on each shift. The alert system includes precautions concerning prescribed medications and medical/mental health conditions. Staff can find this information documented in the youth's file, on the youth's individual MDL's, and on the daily log.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						**YES X NO (explain)** The agency has a policy in place tiled Episodic/Emergency Care to address the requirements of this indicator. The policy was last reviewed on February 9, 2021 by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Off-site Emergency Services							

a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	**X**					There were nine off-site emergency care events reviewed. The shelter maintains an Emergency and Episodic Care Log that documented each incident, all notifications, and discharge instructions. There was also an incident report completed for each event that documented a more detailed explanation of the incident. Each incident was also found documented in the program logbook.	
All staff are trained on emergency medical procedures		**X**				There were nine staff training files reviewed. Eight of the nine staff had current First Aid and CPR certifications.	**Exception:** One staff's First Aid and CPR certification had expired.
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**X**					The program has one knife-for-life and wire cutter kit which is located in the Med Station.	
First aid kit/supplies are fully equipped and inventoried	**X**					The program has seven first aid kits and supplies, which are located in the Med Station, three agency vehicles, the kitchen, the school building, and the administration building. The kits were fully equipped and inventoried regularly.	