FLORIDA NETWORK
of youth and family services

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

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Modified Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for Arnette House for the FY 2021-2022 at its program office located at 2310 NE 24th Street Ocala, FL 34470. Forefront LLC (Forefront) is an independent compliance monitoring firm 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 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 1, 2021 through June 30, 2022.

The review was conducted by Baldwin Davis, Consultant for Forefront LLC, and Peer Reviewer(s). Agency representatives from Arnette House present for the entrance interview were Cheri Pettit, Chief Executive Officer (CEO), Mark Shearon, Chief Operational Officer (COO), Shandra Hope (Clinical Director), Nick Benway (Human Resources Officer), Jason Kasien, Chief Financial Officer (CFO), Pamela Washington (Direct Care Supervisor). The last QI visit was conducted on May 5-6, 2021.

The Reviewer found that Arnette House is in compliance with specific contract requirements. Arnette House **received an overall compliance rating of one hundred percentage (100%) for achieving full compliance** with four applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. There were no corrective actions as a result of the monitoring visit and no recommendation was made.

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

2021-2022 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 05-11-12-2022

Agency Name: Arnette House	**Monitor Name: Baldwin Davis, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 2310 NE 24th Street Ocala, FL 34470**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 11-12, 2022**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
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 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**	☐	☐	☒	☐	☐	Documentation: General Liability through Philadelphia Indemnity Insurance Company, for limits of coverage $1,000,000 each $3,000,000 aggregate and medical expenses of $20,000 for each person; effective 12/01/21 – 12/01/22. Workers Compensation through Associated Industries Insurance Company, Inc. with limits of $1,000,000 each/aggregate, effective 02/28/22 – 02/28/23. 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 12/01/21 – 12/01/22.	**No recommendation or Corrective Action.**

Agency Name: Arnette House						Monitor Name: Baldwin Davis, Lead Reviewer	
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Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): May 11-12, 2022	
	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)
						Florida Network is listed on the Certificate of Insurance as a certificate holder.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are maintained on the hard drive of the CFO's computer. The procedures reviewed appear to be consistent with 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 05/12/2022 by the CEO.	**No recommendation or Corrective Action.**
b. 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 successfully reconciled onsite with the CEO to reflect the fund amount. Petty cash is stored in a locked box in the Administrative Assistants office. The documentation of all receipt totals was provided. The CFO reported all receipts are submitted to him for reimbursement	**No recommendation or Corrective Action.**

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	Explain Rating					Ratings Based Upon:	Notes
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
						once a month. The CFO issues a check and cashes it and the cash is then placed in the petty cash box.	
c. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	**No recommendation or Corrective Action.**
d. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2021, and 2020 was completed by Purvis Gray, C.P.A. and dated December 22, 2021. Per the audit report, a separate Management Letter requiring a Corrective Action Plan is not required and was not issued by the auditor. A copy of the audit was submitted to the FNYFS.	**No recommendation or Corrective Action.**

CONCLUSION

Arnette House has met the requirements for the CINS/FINS contract as a result of full compliance with all four applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. One of the five indicators was not applicable because the provider does not have any current inventory purchased with DJJ/FN Funds. Consequently, **the overall compliance rate for this contract monitoring visit is one hundred (100%) percentage.** 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 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

DATE: May 11-12, 2022

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	**Satisfactory**
1.04 Training Requirements	**Satisfactory**
1.06 Client Transportation	**Satisfactory**

Percent of Indicators rated Satisfactory: 100 %
Percent of Indicators rated Limited: 0 %
Percent of Indicators rated Failed: 0 %

Standard 2: Intervention and Case Management

2.03 Case/Service Plan	**Satisfactory**

Percent of Indicators rated Satisfactory: 100 %
Percent of Indicators rated Limited: 0 %
Percent of Indicators rated Failed: 0 %

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	**Satisfactory**
3.06 Staffing and Youth Supervision	**Satisfactory**

Percent of Indicators rated Satisfactory: 100 %
Percent of Indicators rated Limited: 0 %
Percent of Indicators rated Failed: 0 %

Standard 4: Mental Health/Health Services

4.02 Suicide Prevention	**Satisfactory**
4.03 Medications	**Satisfactory**

Percent of Indicators rated Satisfactory: 100 %
Percent of Indicators rated Limited: 0 %
Percent of Indicators rated Failed: 0 %

Overall Rating Summary

Percent of indicators rated Satisfactory: 100 %
Percent of indicators rated Limited: 0 %
Percent of indicators rated Failed: 0 %

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.

Reviewers

Members

Baldwin Davis - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Peacena Samuels – Regional Monitor, Department of Juvenile Justice

Methodology

This modified review was conducted in accordance with FDJJ-2000 (Quality Assurance Policy and Procedures), and focused in particular areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care/Health Services, and (4) Mental Health/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (Effective January 2022).

Persons Interviewed

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

Documents Reviewed

	Accreditation Reports		Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character		Fire Prevention Plan		Youth Handbook
X	CCC Reports		Grievance Process/Records	8	# Health Records
X	Logbooks		Key Control Log		# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log		# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	6	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	5	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	3	# Youth Records (Open)
X	Fire Inspection Report		List of Supplemental Contracts		# Other: ___
	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

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

Surveys

9	# of Youth	9	# of Direct Staff	0	# of Other

Comments

Due to COVID-19, this review was conducted **onsite using the modified QI review plan**.

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/or community counseling services.

Strengths and Innovative Approaches

The agency received a grant from Clay Electric and was able to prepare the external property grounds for a new playground and ordered new play equipment with the funding received from the grant. Internally, the dayroom was refurbished which included new floors. The bathroom was remodeled to include painting and new cabinets through a grant from First Federal Bank of Florida.

Since the last review and during the 2021/2022 fiscal year, Arnette House purchased a new commercial refrigerator for the shelter. A new roof was installed on the Branan Counseling/Administration building and the pavilion as well as replacement of the camera system following a lightning strike. The agency had extensive tree trimming and removal completed by Ryan VanWagner as a Christmas donation of approximately $10K (donations in-kind). The agency is in the process of constructing a building for the Arnette House Vocation Educational Program which is to be funded by the Sexauer Foundation. After the Tiny House Project that was featured in the previous review report and which was such a success, the Foundation donated money to construct that building to house the program. The agency held the annual Arnette House Boat Regatta and launched the Cash Giveaway fundraiser. Service numbers were added to their Community Counseling and SNAP Program.

Narrative Summary

Standard 1 Arnette House executive team comprises of 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. The agency has employed several positions since the last review period and continues to fill any existing vacancies.

Standard 2 Arnette House provides residential and non-residential counseling and case management services over two counties, Lake and Marion counties that is located in Florida DJJ 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 who have and work from offices onsite. The agency also operates a Stop Now and Plan (SNAP) program at this site. While it is not part of this modified Quality Improvement (QI) Review process, report from the CEO is that it is a highly valuable and successful addition to the program services.

Standard 3 Arnette House residential program is led by a Chief Operations Officer/Shelter Program Manager (a dual role) and a Senior Team Leader who oversee three additional Team Leaders in addition to full-time and part-time Direct Care Workers. The shelter runs three shifts that follows a daily schedule allowing time for school, homework, reading, meals, recreation, and sleeping. Youth have multiple recreation and vocational options onsite to meet the differing needs of all youth served. 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 and serves both CINS/FINS and Department of Children and Families (DCF) program youth in its residential shelter. The agency is preparing for its cyclical reaccreditation with the Council On Accreditation (COA), to be conducted in a few days following this review.

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 are required to receive the mandated training on suicide prevention. Health services are overseen by a part-time registered nurse who is onsite two to three days per week mostly during morning hours. The RN will distribute all medications when onsite and trained youth care workers will distribute medications when the RN is not onsite. 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 onsite. 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. Pyxis reports are generated to review discrepancies and share evidence of good practice in the administration of medication management.

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

Standard 1 – Indicators in this standard address Management Accountability. For the Modified Review process, three (3) indicators were reviewed 1.01, 1.04, and 1.06. Two of the indicators, 1.01 and 1.06, reviewed in Standard 1 were rated Satisfactory with no exceptions, however, indicator 1.04 was rated as Satisfactory with exceptions.

Standard 2 – Indicators in this standard address Intervention and Case Management. For the Modified Review process, indicator 2.03 was reviewed for this standard. Indicator 2.03 was rated Satisfactory with an exception.

Standard 3 – Indicators in this standard address Shelter Care & Special Populations. For the Modified Review process two (2) indicators, 3.01 and 3.06, were reviewed. Indicator 3.01 was rated as Satisfactory with no exceptions and indicator 3.06 was rated Satisfactory with an exception.

Standard 4 – Indicators in this standard address Mental Health and Health Services. For the Modified Review process two (2) indicators, 4.02 and 4.03, were reviewed. Both indicators (4.02 and 4.03) were rated Satisfactory with no exceptions.

Summary of deficiencies resulting in Limited or Failed rating (if applicable):

None of the indicators reviewed were rated Limited or Failed.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators: Add an "**X**" in the applicable column *Satisfactory* *Non- Compliant (E.g. Exceptions)* *No Eligible Items for Review* *No Practice* *Not Applicable*	Satisfactory (S)	Non-compliant (E)	No Eligible Items for Review (N)	No Practice (NP)	Not Applicable (N/A)	**Review Based Upon** **Document Source** *For example: Interview/Surveys, Observation, and/or Type of Documentation*	**Notes** **Explain any items that have any deficiencies, exceptions or are not applicable.**
Standard One – Management Accountability							
1.01: Background Screening (BS) 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** If NO, explain here: The agency has a policy in place to address the requirements of the indicator titled Background Screening. The policy was last reviewed on May 11, 2022 by the Chief Executive Officer.	**Add any exceptions below:**
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 for staff hired with a non-passing/low score.	**X**					A total of fifteen (15) new staff were hired since the last Quality Improvement (QI) review. Eight (8) staff met the criteria for a prescreening assessment. The agency uses the Applicant Risk Profiler. Eight qualifying staff had an Applicant Risk Profiler completed prior to hire and documented a passing score. Seven (7) were interns or volunteers who did not have to do the assessment.	
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 fifteen new staff were hired since the last QI review, including interns and volunteers. All fifteen staff were background screened prior to hire.	

Agency has evidence for employees who have had a break in service and who are in good standing and reemployed with the same agency without an additional suitability assessment or background screening if the break is less than 90 days.			X			The agency has no employees who had a break in service and who are in good standing and reemployed with the agency without an additional suitability assessment or background screening if the break is less than 90 days.	
Five-year re-screening completed every 5 years from initial date of hire	X					There was a total of five staff applicable for a five-year rescreening during this review period. All five staff had a re-screening completed prior to the initial date of hire.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	X					The agency submitted the Annual Affidavit of Compliance with Level 2 Screening via email to the Background Screening Unit on 12/09/2021.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					Documentation of approval of E-Verify work eligibility was provided for all fifteen new staff hired.	
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** If NO, explain here: The agency has a policy to address the requirements of the indicator titled Incident Report – Client. The policy was last reviewed on May 11, 2022 by the Chief Executive Officer.	**Add any exceptions below:**
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				Three (3) first year staff training files were reviewed. Two (2) of the three staff completed DOJ Civil Rights and Federal Funds training within the required time frame.	Exception: One (1) of the new hire staff did not complete DOJ Civil Rights and Civil Funds training until after the required 30 day time frame.

All staff receives all mandatory training during the first 90 days of employment from date of hire.		**X**				Three (3) staff training files were reviewed. One of the three new hire staff completed the 90 day mandatory trainings as required.	Exception: Two (2) staff did not complete their 90 day training requirement of MAB (Managing Aggressive Behavior), Suicide Prevention, CINS Core, Child Abuse and Signs and Symptoms of Mental Health & Substance Abuse.
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**			The agency has no Non-licensed mental health clinical shelter staff who needs to complete Assessment of Suicide Risk Training.	
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).			**X**			The agency has no Non-licensed mental health clinical shelter staff who needs to complete Assessment of Suicide Risk Training.	
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				Three (3) in-service staff training files were reviewed. Two (2) of the three in-service staff completed most of their annual training requirements; one of the three in-service staff's training files included evidence that all of the required training requirements were met and the other staff's training file had all training requirements completed except for 1 missing training. One staff still has a month remaining to complete the remaining 2 trainings; PREA and Sexual Harassment training.	Exception: One (1) staff training file was missing the required annual fire safety equipment training in the file.
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					A total of six (6) training files were reviewed. All six (6) training files included an annual employee training hours tracking form and other related documents as required by the indicator.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES** If NO, explain here: The agency has a policy and procedure to address the requirements of the indicator titled Transport (Non-Medical). The policy was last reviewed on May 11, 2022 by the Chief Executive Officer.	**Add any exceptions below:**
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					The Human Resources (HR) Manager confirmed that in keeping with policy all employees are vetted by their insurance carrier to ensure they are suitable to drive agency vehicles.	

Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	X					There was documentation to show that 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. Florida Department of Motor Vehicles (FDMV) checks are completed on all staff prior to hire and the insurance company is notified of any staff traffic violations 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 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 did not show any single client transports that needed a supervisor's approval prior to the transport taking place.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					The 3rd party present on transports reviewed for the last six months was either an agency staff member or another youth.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	X					The vehicle logs provided for the past six months document each transport; identifying the date and time of the transport, the driver, number of youth, destination and mileage for the vehicle. A sample of log book entries reviewed did not indicate transportation entries. It was observed that this practice is not in compliance with the agency's own policy.	

Standard Two – Intervention and Case Management							
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES** If NO, explain here: The agency has four policies in place titled Case Assignment and Caseload, Case Notes, Case Plan, and Case Plan Review to address the requirements of this indicator. The policy was last reviewed on May 11, 2022 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 NIRVANA	X					Of the eight (8) files reviewed, the service plans were developed within 7 working days of the previously used Needs Assessment tool or the newly implemented NIRVANA.	
Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 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				Eight (8) files were reviewed for case plans. Four (4) case plans included individualized and prioritized needs and goals identified by NIRVANA. However, four (4) case plans were developed before the introduction of NIRVANA. Therefore, the needs and goals were identified by the previous Needs Assessment tool authorized by the Department. Three (3) of the eight case plans did not have actual completion dates, as the youth are still working towards completion of the case plans.	Exception: Two (2) of the eight case plans did not have the youth's signature in the file.
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					Three (3) of the eight (8) case plans reviewed were applicable for 30 day reviews. The three (3) case plans were reviewed as required and met the requirement. Five (5) of the case plans were not applicable for a review because the youth were not in the program long enough.	

Standard Three – Shelter Care							
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES** If NO, explain here: The agency has a policy in place titled Shelter Program Services to address the requirements of this indicator. The policy was last reviewed on February 11, 2022 by the Chief Executive Officer.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Facility Inspection	**X**					On-site tour of the facility revealed that furnishings were appropriate and in good repair. The program was observed to be free of insect infestation. Grounds were landscaped and well maintained. The bathrooms were clean and functional and no graffiti was observed. Lighting was adequate. Exterior areas were free of debris and of any hazards. The dumpster and garbage cans were covered. All doors were secured with key or other security controlled access as required for entry into all buildings. Egress plans of the facility are located at exit doors in each building.	
Additional Facility Inspection Narrative (if applicable)	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 by this indicator. Interior areas of the vans did not contain contraband and were free of hazardous items. Chemicals are stored in locked areas and a weekly inventory and MSDS are maintained on file. The program has three washers and three dryers. All washers and dryers were operational and clean of lint. A current Florida Department of Children and Families (DCF) license was displayed with an effective date of January 9, 2022. Two youth share a room and have their own individual beds with a clean covered mattress, pillow and sufficient linens. All youth are provided with a lockable storage unit to keep personal belongings. The agency did not have a perpetual inventory for the secondary storage area for chemical, however, they implemented one for use while the QI on-site review was in progress.						

Fire and Safety Health Hazards	X					Date of fire inspection(s) reviewed: 07/28/2021	
Additional Fire and Safety Health Hazards Narrative (if applicable)	The annual fire inspection by Ocala Fire Rescue was completed on 07/28/2021. The annual fire sprinkler inspection was February 22, 2022 and the kitchen exhaust extractor was last cleaned and serviced in May 2022. The annual fire extinguisher inspection was in June 2021 while the annual fire alarm inspection was September 17, 2021. A review of drills indicated the program conducted an average of 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 December 8, 2021 and Department of Health (DOH) Food Establishment Inspection was completed on February 3, 2022. Menus were posted and signed by a licensed dietician. Cold food was properly stored, marked, labeled, and the dry storage/pantry areas were clean. Refrigerators/freezers were clean and temperatures were maintained at required levels.						
Youth Engagement							
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	X					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. Nonpunitive structured activities are offered to youth who do not choose to participate in faith-based activities. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. A daily programming schedule is publicly posted and accessible to both staff and youth.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES** If NO, explain here: The agency has a policy in place titled Staffing and Youth Supervision to address the requirements of this indicator. The policy was last reviewed on May 11, 2022.	

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					A review of the 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					A review for the last six months of shifts was conducted. The review included the random sample of log book entries and staff schedules. There was documentation 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 on-site tour, the staff schedule was observed as being 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 current phone listing of staff who may be available when coverage is needed. There is no holdover rotation documentation in place to ensure coverage, however there is a staff number list available and interviewed staff indicated that the COO and Program Manager are the backup for coverages.	

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				There were five random samples of video surveillance reviewed: April 24, 2022 at 2 a.m.; May 2, 2022 at 1:30 a.m. and 2:45 a.m.; May 5, 2022 at 2:15 a.m. and 3:30 am. A review of the above video surveillance sample verified that the staff schedules and the log book entries documented meet the required staffing ratios which were met for awake and sleeping hours.	Exception: The video surveillance system could only go back 20 days and so the review sample was limited to 20 days. Staff were not documenting in real time and while staff were conducting bed checks, the times were consistently off by several minutes. While on-site the COO provided documents to verify the system would be fixed to adhere to standard requirement the following day.
Standard Four – Mental Health/Health Services							
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						**YES** If NO, explain here: Agency has a suicide protocol that meets the indicator.	**Add any exceptions below:**
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					A total of eight (8) files were reviewed-- four (4) shelter files and four (4) community counseling files. Two (2) of each program files were open and two (2) were closed. All eight (8) files indicated a suicide risk screening occurred during the intake process. All eight files indicated intake screening results were reviewed by the supervisor and documented in youth's case file.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					The program uses a suicide risk assessment that has been approved by the Florida Network of Youth and Family Services.	

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 (3) youth were placed on suicide precaution during the intake process. A suicide risk assessment was completed on all three youth within 24 hours by a licensed professional. All three youth were removed from suicide precaution based on the results of the assessment.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					Documentation on all three (3) files indicated youth were monitored by staff at 10 minute 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					All three (3) files indicated youth remained on suicide precaution until seen and assessed by a licensed professional at which time they were removed from suicide observation.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES** If NO, explain here: The agency has a policy in place titled Medication Distribution for Non-Healthcare Staff to address the requirements of this indicator. The policy was last reviewed on May 11, 2022 by the Chief Executive Officer.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Medication Storage							
a. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Med-Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK-LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	X					An observation of the Pyxis Med-Station 4000 showed the Pyxis Med-Station is located in the RN's office and it is not accessible to youth. The on-site observation revealed that all medication, to include Narcotics and controlled medications, are secured and stored in the Pyxis Med-Station cabinet. Oral medications are stored separately from injectable epi-pen and topical medications. Medications requiring refrigeration were secured and stored in the refrigerator at 42 degrees F. An observation of the Pyxis keys showed the keys were accessible to staff if there is a Pyxis malfunction, and medication is needed. The keys are labeled as required by the review standard.	

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 injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse	**X**					The program has two Super Users for the Pyxis Med Station. A review of four non-licensed staff and Registered Nurse (RN) medication training certifications was conducted during the compliance review. The review indicated only designated staff are delineated in User Permissions to have access to the secured medications and controlled substances. The non-licensed staff are trained by the nurse. A review of the medication distribution log (MDL) indicated licensed and non-licensed staff utilizes the MDL for medication distribution. Medications are verified with the pharmacy before being placed in the Pyxis. The RN distributes medication when on-site. The program does not accept injectable medications, except epi-pens.	

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 review of the MDL and Medication Count form was conducted with the RN. The review indicated that there is a perpetual inventory with running balances maintained as well as a shift to shift count is verified by a witness and documented. Over-the-counter medications are inventoried weekly by the RN who maintains a perpetual inventory. Syringes and sharps are observed as being secured and counted, and documented weekly on a weekly sharps inventory log.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	**X**					The program extracts weekly medication distribution reports and monthly reviews of medication management practice via Pyxis Med-Station Reports.	
Medication discrepancies are cleared after each shift.			**X**			The agency's RN reported common practice is to clear discrepancies after each shift. However, there were no discrepancies to review or verify during the review period.	