Florida Network for Youth and Family Services
Compliance Monitoring Report for

Arnette House
2310 NE 24th Street
Ocala, FL 34470

April, 12-13 2023

Compliance Monitoring Services Provided by

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 (Ocala) for the FY 2022-2023 at its program office located at 2310 NE 24th Street Ocala, FL 34470. 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 1, 2022 through June 30, 2023.

The review was conducted by Baldwin Davis Consultant for Forefront LLC, and Department of Juvenile Justice Peer Reviewer, Meghan Thrasher. 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), Nicholas Benway, Human Resources Officer (HRO), Maria Hiney (HR Assistant), Cindy Moore (Community Coordinator), Jason Kasien Chief Financial Officer (CFO), Pamela Washington (Shelter Supervisor), Melissa Grzyb (Intake Coordinator). The last QI visit was conducted May 11-12, 2022.

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

2022-2023 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 04-13-2022-2023

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): April 12-13, 2023**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:**	**Notes**
	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)**
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 of $1,000,000 each $3,000,000 aggregate and medical expenses of $20,000 for each person; effective 12/01/22 – 12/01/23. Workers Compensation through Associated Industries Insurance Company, Inc. with limits of $1,000,000 each/aggregate, effective 02/28/23 – 02/28/24. 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 12/01/22 – 12/01/23. Florida Network is listed on the Certificate of Insurance as a certificate holder.	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
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**	☐	☐	☒	☐	☐	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 04/04/2023 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 to reflect the current balance of $176.01. Petty cash is stored in a locked box in the Administrative Assistants (AA) office. The documentation of all receipt totals was provided and the AA reported all receipts are submitted to the CFO for reimbursement once a month. The CFO issues a check and cashes it and the cash is then placed in the petty cash box.	**No recommendation or Corrective Action.**
c. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over	☐	☐	☐	☐	☒	Observation/Documentation:	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
$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.	
d. 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 and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: The financial audit conducted for the year ending June 30, 2021, and 2022 was completed by Purvis Gray, C.P.A. and dated March 30, 2022. 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 percent (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 indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

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: April 12-13, 2023

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
Meghan Thrasher – Regional Monitor, Department of Juvenile Justice

Methodology

This review was conducted in accordance with FDJJ-2000 (Quality Assurance Policy and Procedures), and focused on the 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 September 1, 2022).

Persons Interviewed

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

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records		# Health Records
X	Logbooks		Key Control Log		# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log		# Personnel /Volunteer Records
	Contract Monitoring Reports	X	Medical and Mental Health Alerts	6	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	4	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	6	# Youth Records (Open)
X	Fire Inspection Report		List of Supplemental Contracts		# Other: ___
	Exposure Control Plan	X	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	6	# of Direct Staff	2	# of Other

Comments

Due to the systemic staffing issues which impact the availability for member agencies to participate in the QI Peer Review team review, this review was conducted using the Modified QI Review Tool.

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

Arnette House, Inc. was formed in 1979 and today, Arnette House, Inc. is a three-building complex on 4.8 acres in Northeast Ocala in Marion County that includes an emergency shelter, the Branan Counseling and Administration building, and the Vernon Arnette Educational Center which includes the SNAP House program. In 2009, two foster care Group Homes were added as Arnette House's reach now also extends into Lake County to support its children through initiatives such as the Safe Place Program and an extensive Outreach and Prevention Program including non-residential counseling.

The following programmatic updates were provided by the agency:
The agency continues to provide key CINS/FINS services to Marion, Lake, Sumter Counties, Florida and within the Department of Juvenile Justice (DJJ) Judicial Circuit #5. The agency accepts referrals from established partners and the local schools. The agency also receives referrals from youth, parents/guardians, and local community-based organizations. The agency trains all staff members to screen for presenting problems, current risk, and CINS/FINS eligibility criteria to determine the needs of the family and youth. The agency has screening, intake and assessment components to address an array of various issues presented by youth and their families. The agency had adopted a service model that meets today's challenges that includes groups and family counseling which happens in person and virtually, when necessary.
Arnette House is currently run by a vibrant array of experienced dedicated and knowledgeable staff while still experiencing post Covid staffing challenges. Since the last review, the Assistant Shelter Manager retired and her position was deleted and the Direct Care Supervisor was promoted to Shelter Supervisor, one Shift Supervisor resigned and they hired a replacement staff. Their Community Development Coordinator of many years went into retirement. The agency subsequently hired a replacement Coordinator who didn't work out and so the retired Coordinator returned on a part-time basis. One CINS/FINS community counselor resigned and so the agency increased the remaining counselor's caseloads and salary to cover that position. Two SNAP members of staff left, one retired and the other accepted a job with the school system. An additional SNAP member is leaving the agency soon for family reasons. They hired one new part-time SNAP employee so far as the Clinical Supervisor covers groups and interns are assisting as the open positions are advertised. The agency also hired a new RN in March 2023. In the process of solidifying their staff team, the agency made a significant enhancement to its programs offered to youth and families to include, developing an Enhanced Vocational Program where youth are able to learn building and maintenance skills, first hand.

Recent updates to the facility and notable since the last review includes an enhanced playground and increased parking lot capacity, tree trimming and removal has been an intentional improvement to controlling the surrounding environment and mitigating its own facility. Internally, they have remodeled kitchens in the administrative building. Planned facility updates for the future, includes a phase two of playground upgrades, completing the parking lot and installing new air conditioner units to the administrative and SNAP buildings. They secured two used cars donations and which they make available for staff use only, youth are not transported in these vehicles. New funding was secure by way of the American Rescue Plan Act (ARPA) and fundraising continues to be an active occurrence for the agency including their Annual Boat Regatta, an annual $10,000 Giveaway and an Inaugural Boat Poker Run. In terms of Board and Governance within the last year, the agency conducted ten Board Meetings to meet their governance requirements and brought on two new board members. New community partnerships and stakeholders, both non-profit and corporate, includes, Black Label Marine, Kimberly's Center, Gator Joes, Eatons Beach, Ride Now and Paddock Mall. For Mental Health Agreements, they have secured a new provider, Stuart Marchman Act Behavioral Healthcare. At this point, staffing issues are a critical and single most important concern for the agency.

Narrative Summary

Arnette House executive team comprises of a Chief Executive Officer (CEO) and Chief Operating Officer (COO). The COO oversees one Shelter Supervisor and three other Team Leaders who operate the shelter. The COO and Shelter Supervisor who was promoted to that position since the last review, oversee the day-to-day operations of the shelter. The agency has employed several positions since the last review period and continues to work diligently to fill any existing vacancies.
Arnette House provides residential and non-residential counseling and case management services over three counties, Lake, Sumter and Marion counties that is located in Florida DJJ Circuit 5. The Clinical Supervisor is a Licensed Mental Health Counselor (LMHC) who oversees both residential and community based programs and has a long tenure at the agency. The residential counseling program consists of one Counselor. The non-residential program consists of four Counselors who have and work from offices on-site. The agency also operates a Stop Now and Plan (SNAP) program at this site and which is not part of this modified Quality Improvement (QI) Review process.

There continues to be shortage of qualified persons locally for existing shelter vacancies at which time the agency has six direct care CINS/FINS funded staff vacancies. CEO confirmed that salaries will have to be substantially increased to meet the required staffing need and retention, however such an increase could have a detrimental impact on the agency being unable to sustain some services. The shelter operates 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 and has a very well stocked inventory of incentive items. Arnette House is licensed by the Department of Children and Families for twenty beds and serves both CINS/FINS and Department of Children and Families (DCF) program youth in its residential shelter at the time of the review there was census of ten youth. The agency has a successful reaccreditation with the Council On Accreditation (COA) since the last QI review.

While the residential counseling services in the shelter are overseen by the Clinical Supervisor, who is a Licensed Clinical Social Worker (LCSW), the direct clinical services are provided by a master's level, residential counselor. In addition, the program's Chief Executive Officer is also a LMHC. All youth are screened for suicide risk 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 newly appointed registered nurse (RN). The RN distributes 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 is responsible to complete 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 distributed. The agency's policy states that Pyxis reports are to be done 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: Management Accountability had three indicators reviewed for this standard. All three of the indicators reviewed in were rated satisfactory with an exception for 1.04 and no exceptions noted for indicators 1.01 and 1.06.
Standard 2:Intervention and Case Management had one applicable indicator reviewed for this standard. The one indicator 2.03, was rated satisfactory with no exceptions.
Standard 3: Shelter Care & Special Populations had two indicators reviewed for this standard. Both indicators 3.01 and 3.06 were rated satisfactory with no exceptions.

Standard 4: Mental Health and Health Services had two indicators reviewed for this standard. Both indicators 4.02 and 4.03 were rated satisfactory with an exception.

Summary of Deficiencies resulting in Limited or Failed Rating (If Applicable):

The agency did not have any indicators that resulted in a limited or failed rating.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator.		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			**Satisfactory**
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 FLN1.01 in place to address the requirements of the indicator titled Background Screening. The policy was last reviewed on April 4, 2022 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 for staff hired with a non-passing/low score.	**Compliance**	A total of twelve new staff were hired since the last Quality Improvement (QI) review. Twelve staff met the criteria for a prescreening assessment. The agency uses the Applicant Risk Profiler. All twelve qualifying 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	**Compliance**	A total of twelve new staff were hired since the last QI review. All twelve 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.	**No eligible items for review**	The agency has no employees with a break in service greater than 90 days during the period under review.	
Five-year re-screening completed every 5 years from initial date of hire	**Compliance**	There was a total of five staff applicable for a five-year rescreening during this review period. Two of the five staff had a re-screening completed within the required timeframe. Three staff had rescreening done prior to their five year rescreening date because their fingerprints expired in the Clearinghouse. All staff were rescreened before the fingerprint expiration date.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The agency submitted the Annual Affidavit of Compliance with Level 2 Screening via email to the Background Screening Unit on 01/18/2023 and to the Florida Network on 01/23/2023.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Documentation of approval of E-Verify work eligibility was provided for all twelve new staff hired.	
Additional Comments: **There are no additional comments for this indicator.**			
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)			**Exception**
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 FLN1.04 in place to address the requirements of the indicator titled Training. The policy was last reviewed on April 4, 2022 by the Chief Executive Officer.	
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	Five first year direct care staff training files were reviewed and all reviewed staff completed new hire pre-service training requirements for safety and supervision as required.	

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)*	**Compliance**	Five first year direct care staff training files were reviewed and all reviewed staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from the date of hire.	
All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Compliance**	Five first year direct care staff files were reviewed and all reviewed staff exceeded the required 80 hours of training.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Five first year direct care staff files were reviewed. Two of the five reviewed staff had all of the required training completed within the required time frame within the initial 90 days of hire.	One staff hired on August 8, 2022 did not complete the SkillPro Suicide Awareness and Prevention course until November 16, 2022 and it was due no later than November 6, 2022. One staff hired on July 13, 2022 did not complete Instructor led Managing Aggressive Behavior until November 9, 2022 and a three hour virtual training on October 21, 2022 and it was due no later than October 10, 2022. The final staff hired on April 29, 2022 did not complete the SkillPro Trauma Informed Care course until August 13, 2022, the SkillPro Suicide Awareness and Prevention course until August 13, 2022, and the SkillPro Information Security Awareness course until August 2, 2022 when all three were due no later than July 27, 2022.
Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**Compliance**	Although three of the five direct care staff files reviewed completed the NIRVANA data entry training, it was in addition to their required courses.	

Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
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).	**Not Applicable**	There were no non-licensed clinical staff that required the training during the 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).*	**Compliance**	Three in-service direct care staff training files were reviewed. All staff exceeded the required number of hours for Florida Network, SkillPro, and job-related refresher training annually to include the number of hours required due to the agency having a DCF child caring license.	
Required Training Documentation			
The agency has a designated staff member responsible for managing all employee's individual training files and completes routine reviews of staff files to ensure compliance.	**Compliance**	The agency has a designated staff member responsible for managing all employee individual training files and completing routine reviews of staff files to ensure compliance.	
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	The agency maintains an individual training file for each staff to include an annual employee training hours form and related documentation.	
Additional Comments: **There are no additional comments for this indicator.**			

1.06: Client Transportation			Satisfactory
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 FLN1.06 in place to address the requirements of the indicator titled Client Transportation. The policy was last reviewed on April 4, 2022 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	**Compliance**	There is specific HR hiring policy, agency property and vehicle policy and 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.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	There is specific HR hiring policy, agency property and vehicle policy and 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	**Compliance**	The policy titled Client Transportation 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	**Compliance**	A review of vehicle logs for the last six months showed one single client transportation that provided a supervisor's approval prior to the transport taking place.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The 3rd party present on transports reviewed for the last six months was either an agency staff member or another youth.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Compliance**	During the review period there was one single transport conducted on 2/27/2023. The agency demonstrated evidence via log signature verification that supervisor approval was obtained prior to that single youth transport.	
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.	**Compliance**	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.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has a policy FLN1.06 in place to address the requirements of the indicator titled Case/Service Plan. The policy was last reviewed on April 4, 2022 by the Chief Executive Officer.	
The case plan is developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA.	**Compliance**	Ten youth case management records were reviewed, five of which were residential and five community based records. Six were open case records and four were closed at the time of the review. All ten youth records contained case plans developed based on information gathered during the initial screening, intake, suicide screening, and NIRVANA.	

Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	Case/Service plans were developed within seven working days of NIRVANA completion in all ten youth case management records reviewed.	
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	**Exception**	In nine of ten records reviewed the case plans included individualized and prioritized needs and goals identified by the NIRVANA, the service type, frequency, and location, the person or persons responsible, target dates for completion and actual completion dates, all required signatures to include the parent, youth, counselor, and supervisor, and the date the plan was initiated.	One youth record contained a case plan that had all required elements except the supervisor signature.
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	**Compliance**	Five of ten youth case management records were applicable for reviews. In all five records the case plans were reviewed for progress and revised by the counselor and parent every thirty days. No records were applicable for being in services longer than six months.	
Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			**Satisfactory**
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 FLN3.01/3.02/3.05/3.06 and 4.01 in place to address the requirements of the indicator titled Shelter Program Services. The policy was last reviewed on April 4, 2022 by the Chief Executive Officer.	

Facility Inspection	**Compliance**	On-site tour of the facility revealed that furnishings were adequate and in good repair. The program was observed to be free of insect infestation. The tree filled 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 locks 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, in the common area, as well as in the kitchen.	
Additional Facility Inspection Narrative (if applicable)	Grievance forms, abuse hotline information, DJJ Incident Reporting number and other relevant 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 for the secondary and primary areas of chemical storage. The agency does have a perpetual inventory for the secondary storage and management of chemicals. 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 30, 2023. 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.	

Fire and Safety Health Hazards	**Compliance**	The annual fire inspection by Ocala Fire Rescue was last completed on 09/20/2022. The annual fire sprinkler inspection was 2/27/2023 and the kitchen exhaust extractor was last cleaned and serviced in3/3/2023. The annual fire extinguisher inspection was in 9/2/2022 while the annual fire alarm inspection was done on 6/23/2022. A review of the drill log 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 12/9/2022 and Department of Health (DOH) Food Establishment Inspection was completed on 3/17/2023. Menus were posted and signed by a licensed dietician. Cold food was properly stored in refrigerators, properly marked and labeled as well as the dry storage/pantry areas were clean. Refrigerators/freezers were clean and temperatures were maintained at required levels.	
Additional Fire and Safety Health Hazards Narrative (if applicable)			
Grievance			
There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Compliance**	Site visit observation and interview concluded that there are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth is placed in the common area.	

There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook. All grievances are resolved within 72 hours and documented by program director.	**Compliance**	Site visit evidence demonstrates that grievance boxes are checked by management or a designated supervisor at least daily. Grievances are to be resolved within 72 hours and documented by program director. One grievance was documented on the form for the complaint reviewed. It was somewhat unclear from the grievance form and documentation reviewed, to establish the timeline for dealing with grievances. Prior to leaving the review, the program made appropriate modifications to the form so that timeline for resolution can be captured as well as sign off signature dates.	
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.	**Compliance**	Youth are engaged in meaningful, structured activities seven days a week during awake hours and so idle time is minimal. The activity schedule provided indicates that 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.	
Additional Comments: **There are no additional comments for this indicator.**			

3.06 - Staffing and Youth Supervision			Satisfactory
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 FLN 3.06 in place to address the requirements of the indicator titled Shelter Services Staffing. The policy was last reviewed on April 4, 2022 by the Chief Executive Officer.	
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	**Compliance**	A review of the video surveillance sample, staff schedules and log book entries documented that the required staffing ratios were met for awake hours and sleeping hours.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	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.	**Compliance**	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	**Compliance**	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	**Compliance**	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 as a last resort for coverage 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	**Compliance**	Staff are trained to observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times. There were six random samples of video surveillance reviewed: 3/14/2023 at 2:15 a.m., and 5:00 a.m.; 3/19/2023 at 3:30 a.m. and 1:30 a.m.; 4/10/2023 at 12:45 a.m. and 4/11/2023 at 3:31 a.m. A review of the above video surveillance sample verified that the staff schedules and the log book entries documented met the required staffing ratios for awake and sleeping hours. All the times logged for bed checks were precise.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The agency has a policy FLN4.02 in place to address the requirements of the indicator titled Suicide Prevention. The policy was last reviewed on April 4, 2022 by the Chief Executive Officer.	
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
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.	**Compliance**	Eight youth case management records were reviewed, four open and four closed. All records contained a suicide screening completed during the initial intake and screening process. The suicide screening results were all reviewed and signed by the supervisor and documented in the youth's case record.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The agency utilizes the CINS/FINS intake form which includes a suicide risk assessment that has been approved by the Florida Network of Youth and Family Services.	

Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	Three of the four applicable youth in shelter services were applicable for being placed on constant sight and sound supervision. All four youth were placed appropriately based on the results of the suicide risk assessment.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**Compliance**	Three of four shelter youth were placed on constant sight and sound. While on constant sight and sound supervision, the staff person assigned to the youth documented the youth's behavior at ten 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	**Compliance**	Three of four shelter youth were placed on constant sight and sound supervision. This supervision level was not changed or reduced until a licensed mental health professional completed a further assessment.	
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**No eligible items for review**	Four community youth case management records were reviewed. No youth were identified for suicide risk during intake.	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**No eligible items for review**	Four community youth case management records were reviewed. No youth were identified for suicide risk during intake.	

Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**No eligible items for review**	Four community youth case management records were reviewed. No youth were identified for suicide risk during intake.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	Four community youth case management records were reviewed. No youth were identified for suicide risk during intake.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	Four community youth case management records were reviewed. No youth were identified for suicide risk during intake.	
Additional Comments: **There are no additional comments for this indicator.**			
4.03 - Medications			**Exception**
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 FLN 4.03 in place to address the requirements of the indicator titled Medication Management and Distribution. The policy was last reviewed on April 4, 2022 by the Chief Executive Officer.	
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	The agency has one Registered Nurse (RN) staff who has a clear and active license in the state of Florida that does not expire until July 31, 2024.	

Medication Storage			
a. All medications are stored in a Pyxis ES 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 Pyxis ES 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	**Compliance**	A virtual tour of the Pyxis Med-Station and medical room was completed with the Registered Nurse (RN) and Direct Care Supervisor on-site. The Pyxis Med-Station is located in the medical room of the shelter building and is inaccessible to youth. All medications are stored in the Pyxis Med-Station 4000 medication cabinet. Oral medications are stored separately in a locked cabinet apart from topical medications and epi-pens. There is a secure refrigerator in the medical room used only for medical purposes and maintained within the required temperature range. At the time of the review, there were no medications on-site requiring refrigeration. All narcotic and controlled medications are stored in the Pyxis Med-Station 4000 medication cabinet.	

Medication Distribution			
a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES 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 three methods listed in the FNYFS Policies & Procedures 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	**Compliance**	A virtual tour of the Pyxis Med-Station and medical room was completed with the Registered Nurse (RN) and Direct Care Supervisor. A list of System Managers was provided as well as a list of designated staff delineated to have access to the secure medication. Training documents support all applicable staff were trained by the agency's medical staff in medication distribution. A review of the agency's medication log book verified the agency is utilizing a tracking log for distribution of medication to all youth by any non-licensed or licensed staff. The agency verifies medication using one of the required three method listed in the FNYFS Policies and Procedures Manual. When the nurse is on site, the nurse is the only person who conducts medication processes and the delivery process is consistent with the FNYFS Medication Management and Distribution Policy. The agency does not accept youth into the shelter who are currently prescribed any injectable medication except epi-pens. Eight direct care staff training files were reviewed, five pre-service and three in-service. All staff had received training in the use of 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	**Exception**	The agency utilizes their Pyxis Med-Station and Medication Distribution Log to maintain a perpetual inventory of all controlled substances. The Medication Distribution Log contains a running balance for each youth as well as a shift to shift count that is verified by a witness and documented. The agency's Medication Distribution Log also contains weekly inventories maintained on over-the-counter medications that are accessed regularly. The agency is consistently maintaining a bi-weekly syringe and sharps inventory count.	The Registered Nurse (RN) and Direct Care Supervisor were advised the inventory for sharps and syringes needs to be conducted weekly.
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Exception**	Since the last annual compliance review a monthly review of Pyxis reports to monitor medication management practice has been completed except for one month.	Monthly reviewed reports were maintained from the last compliance review through February of 2023 when the previous nurse resigned. Therefore; the month of March 2023 was not reviewed. The current Registered Nurse (RN) and Direct Care Supervisor were recommended to continue to conduct these reviews moving forward.
Medication discrepancies are cleared after each shift.	**Compliance**	The agency maintains a binder with all discrepancies and how they were cleared, confirming discrepancies are cleared after each shift. At the time of the review there were no open discrepancies.	
Additional Comments: **There are no additional comments for this indicator.**			