QUALITY IMPROVEMENT PROGRAM REPORT FOR

Miami Bridge Youth and Family Services
(Central Service Location)

2810 Northwest South River Drive
Miami, FL 33125
(Local Service Provider)

Review Date(s):
March 13-14, 2012
# CINS/FINS Rating Profile

**Program Name:** Central Program  
**Provider Name:** Miami Bridge Youth and Family Services  
**Location:** Miami Dade / Circuit 11  
**Review Date(s):** March 13-14, 2012  
**QA Program Code:** N/A  
**Contract Number:** V2021  
**Number of Beds:** 28  
**Lead Reviewer:** K. Carr

## Indicator Ratings

### 1. Management Accountability

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.01</td>
<td>Background Screening of Employees/Vol.</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>1.02</td>
<td>Provision of an Abuse Free Environment</td>
<td>Limited</td>
</tr>
<tr>
<td>1.03</td>
<td>Incident Reporting</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>1.04</td>
<td>Training Requirements</td>
<td>Limited</td>
</tr>
<tr>
<td>1.05</td>
<td>Interagency Agreements and Outreach</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>1.06</td>
<td>Disaster Planning</td>
<td>Satisfactory</td>
</tr>
</tbody>
</table>

% Indicators Rated Satisfactory Compliance: 67%  
% Indicators Rated Limited Compliance: 33%  
% Indicators Rated Failed Compliance: 0%

### 3. Shelter Care/Health Services

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.01</td>
<td>Shelter Care Requirements</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>3.02</td>
<td>Healthcare Admission Screening</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>3.03</td>
<td>Suicide Prevention</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>3.04</td>
<td>Medications</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>3.05</td>
<td>Medical/Mental Health Alert Process</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>3.06</td>
<td>Episodic/Emergency Care</td>
<td>Satisfactory</td>
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% Indicators Rated Satisfactory Compliance: 100%  
% Indicators Rated Limited Compliance: 0%  
% Indicators Rated Failed Compliance: 0%

### 2. Intervention and Case Management

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.01</td>
<td>Screening and Intake</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.02</td>
<td>Psychosocial Assessment</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.03</td>
<td>Case/Service Plan</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.04</td>
<td>Case Management and Service Delivery</td>
<td>Limited</td>
</tr>
<tr>
<td>2.05</td>
<td>Counseling Services</td>
<td>Limited</td>
</tr>
<tr>
<td>2.06</td>
<td>Adjudication/Petition Process</td>
<td>Satisfactory</td>
</tr>
</tbody>
</table>

% Indicators Rated Satisfactory Compliance: 67%  
% Indicators Rated Limited Compliance: 33%  
% Indicators Rated Failed Compliance: 0%

## Overall Rating Summary

- **Satisfactory Compliance:** 78%  
- **Limited Compliance:** 22%  
- **Failed Compliance:** 0%
Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, and (3) Shelter Care/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2011).

Persons Interviewed

- ✗ Program Director
- [ ] DJJ Monitor
- [ ] DHA or designee
- [ ] DMHA or designee

- 2 # Case Managers
- 2 # Clinical Staff
- 1 # Food Service Personnel
- 1 # Healthcare Staff
- 1 # Maintenance Personnel
- 3 # Program Supervisors
- [ ] Other (listed by title): Chief Compliance, Dir Admin & Clin.

Documents Reviewed

- [ ] Accreditation Reports
- [ ] Affidavit of Good Moral Character
- [ ] CCC Reports
- [ ] Confinement Reports
- [ ] Continuity of Operation Plan
- [ ] Contract Monitoring Reports
- [ ] Contract Scope of Services
- [ ] Egress Plans
- [ ] Escape Notification/Logs
- [ ] Exposure Control Plan
- [ ] Fire Drill Log
- [ ] Fire Inspection Report
- [ ] Fire Prevention Plan
- [ ] Grievance Process/Records
- [ ] Key Control Log
- [ ] Logbooks
- [ ] Medical and Mental Health Alerts
- [ ] PAR Reports
- [ ] Precautionary Observation Logs
- [ ] Program Schedules
- [ ] Sick Call Logs
- [ ] Supplemental Contracts
- [ ] Table of Organization
- [ ] Telephone Logs
- [ ] Vehicle Inspection Reports
- [ ] Visitation Logs
- [ ] Youth Handbook
- 6 # Health Records
- 6 # MH/SA Records
- 9 # Personnel Records
- 8 # Training Records/CORE
- 7 # Youth Records (Closed)
- 18 # Youth Records (Open)
- 3 # Other: Outreach Information

Surveys

- 3 # Youth
- 4 # Direct Care Staff
- 0 # Other: _____

Observations During Review

- ✗ Admissions
- ✗ Confinement
- ✗ Facility and Grounds
- ✗ First Aid Kit(s)
- ✗ Group
- ✗ Meals
- ✗ Medical Clinic
- ✗ Medication Administration
- ✗ Posting of Abuse Hotline
- ✗ Program Activities
- ✗ Recreation
- ✗ Searches
- ✗ Security Video Tapes
- ✗ Sick Call
- ✗ Social Skill Modeling by Staff
- ✗ Staff Interactions with Youth
- ✗ Staff Supervision of Youth
- ✗ Tool Inventory and Storage
- ✗ Toxic Item Inventory and Storage
- ✗ Transition/Exit Conferences
- ✗ Treatment Team Meetings
- ✗ Use of Mechanical Restraints
- ✗ Youth Movement and Counts

Comments

- [ ] Items not marked were either not applicable or not available for review.
Rating Definitions

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

<table>
<thead>
<tr>
<th>Rating Definitions</th>
<th>Description</th>
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<tbody>
<tr>
<td>Satisfactory Compliance</td>
<td>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.</td>
</tr>
<tr>
<td>Limited Compliance</td>
<td>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.</td>
</tr>
<tr>
<td>Failed Compliance</td>
<td>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.</td>
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</tbody>
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Review Team

The Florida Network of Youth and Family Services would like to thank the following review team members for their participation in this review, and for promoting continuous improvement and accountability in juvenile justice programs and services in Florida:

Keith D. Carr, Lead Reviewer, Principal Consultant, Forefront LLC
Marie Boswell, Delinquency Prevention Specialist, Office of Prevention and Victim Services
Tom Mahoney, Quality Improvement Review Analyst, DJJ Bureau of Quality Improvement
Rachayle McKinney Quality Management Specialist, Children’s Home Society
Miami Bridge Central Shelter (Miami) is a Child in Need of Services and Family in Need of Services (CINS/FINS) program operated by Miami Bridge Youth and Family Services, Inc. (Miami Bridge). The program has a central office and shelter located in North Miami, Florida, and a south shelter located in Homestead, in southern Miami-Dade County. The current agency leadership structure consists of the Board of Directors, Executive Director, Chief Compliance Officer, Director Administrative Services, and Clinical Supervisor that is responsible for the clinical supervision of the programs. The program serves male and female youth between the ages of ten to seventeen years that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The program provides a full range of residential and non-residential services designed to maintain family structure, reduce truancy, as well as prevent and reduce the number of children that enter the Department of Juvenile Justice (DJJ) and the Department of Children and Families (DCF). An array of residential services are provided that include education, recreation, counseling, referrals and behavior management components. The First Stop non-residential services program consist of individual and family counseling and case management services. The program is a designated Safe Place site.

Miami Bridge Central location recently received donated exterior and interior renovations from Coastal Construction, a construction contracting company that updated the facility with priming, new painting, bathroom updates, as well as other cosmetic enhancements.

Miami Bridge is certified by the Council of Accreditation (COA). The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards.

Miami Bridge has licensed mental health professionals contracted with the agency to review and provide oversight over its counseling services in both the residential and non-residential CINS/FINS programs at both program location in Miami and Homestead.

Miami Bridge has established partnerships with both the local University and Hospital. The agency has also secured weekly participation from Volunteers that include the Village, Youth for Christ and Miami-Dade County Domestic Violence Prevention.

**Standard 1: Management Accountability**

**Overview**

Miami Bridge is governed by a Board of Directors that represent a vast cross section professions and industries. Mary Andrews, Executive Director oversees the Miami Bridge program and the services provided through its two (2) service locations in Miami and Homestead, Florida. At the time of this review, according to agency’s organizational chart lists Baldwin Davis, MS, Chief Compliance Officer, David Sharfman, MS, Director of Administrative Services, Alan Davidson, Financial Services, John Piedrahita, MS, Director of the Miami Site and Clinical Services, Mary Behr,
MS, Director of Community Base Services, Regina Vendrys, LMHC (contractor), Cheryl Polite Eaford, LCSW (contractor) and six (6) counselors. John Piedrahita, Director of Miami Site and Clinical Services also manages a case load of clients and oversees all direct care staff and recreational activities. In addition, the agency organizational chart lists various manager and executive assistant and professional assistant positions.

At the time of this review, there are over thirty (30) Volunteers listed by the agency. At the time of the quality improvement review, the residential program lists no vacancies and the non-residential program lists 1 Assistant’s position on the organizational chart under counselors. The Department of Children and Families has licensed Miami Bridge Central as an emergency runaway shelter, with the current license in effect until May 31, 2012.

The agency handles all personnel functions of its 2 service locations through its Human Resources division located at its central office in Miami, Florida. This office processes all state and local background screenings and human resource functions. Annual training is tracked according to the employee’s date of hire. An individual training file is maintained for each employee, which includes supporting documentation such as sign-in sheets and certificates. The provider agency conducts orientation training to all shelter personnel through a combination of training sources that include the Florida Network, local area and in-house trainers. Each employee has a separate training file containing and the system is designed for each to have a Program Orientation, a training plan and verification of training topics and courses completed for training received.

Over the past several months Miami Bridge has experienced a series of recent departures in key leadership positions within the agency. These departures are the result of terminations of employment, as well as resignations. Many of these departures involved key and management positions that impact the operations and programming at both service locations. Mary Andrews, Executive Director of Miami Bridge informed the Review Team that the organization was in the midst of several staff members leaving the agency prior to this review. She stated that there were justifiable reasons for these departures. She referenced issues of staff member non-performance, violations of the employee code of conduct policy, insubordination, as well as general attrition. She further stated that some the key staff members that were no longer employed with Miami Bridge tried to sabotage the agency prior to their departure by getting rid of systems and processes related to staff training and fiscal procedures. She specifically referenced that a universal training file with all employee trainings had temporarily gone missing and an interruption in payroll had also occurred. Keith Carr, Lead Reviewer, mentioned past complaint calls to the Florida Network of Youth and Family Services and DJJ Office of Prevention and Victim Services regarding Miami Bridge related to accusations of not providing a safe and secure environment, unprofessional staff members and potentially unacceptable shelter conditions. These complaints were determined to be unfounded following onsite investigations by DJJ, Florida Network and DCF.

It was the concern of the review team that these events have resulted in a few remaining current management personnel being assigned multiple tasks, duties and responsibilities. These major staff member changes require current staff members to perform and be responsible for many duties beyond what may reasonable for them to effective. This may increase the agency’s exposure level to various risk management issues. The Review Team is concerned that basic systems and internal controls are weakened when current staff members have several assigned responsibilities that they are required to do, as well as supervise employees and ensure that youth and families are receiving high quality services. Although Miami Bridge is working to resolve these issues there are concerns regarding its ability to manage potential risks at this
time. In general the review team is concerned about the agency’s current ability to restore and establish consistency regarding internal fiscal, administrative and operational functions.

**1.01: Background Screening of Employees/Volunteers**

Satisfactory Compliance

The agency has a background screening policy that addresses the major requirements of this standard. The policy is dated and indicates that it was last updated in July 2009. A total of nine (9) applicable personnel files were reviewed to verify and confirm the agency’s compliance regarding this standard. Of these files, all screenings conducted on new/recently hired staff members indicate that each was screened prior to their date of hire. In addition, two (2) 5 year rescreens were reviewed to assess compliance with this standard. Both 5 year rescreens completed by the agency have sufficient evidence that indicated that they were rescreened prior to their 5 year anniversary date.

Two (2) employee screenings had eligible charges that required both to utilize the exempt process to hire these staff members. At the time of this onsite review, the agency did not have any volunteers that offered their services for more than ten (10) hours per month. All volunteer are supervised and do not have access to confidential records.

All files reviewed also contain information that demonstrates that the agency conducts local background checks and driver’s license checks prior to hiring applicants. The agency also conducts random drug screens on all staff members. The agency has also demonstrated and provided evidence that the Annual Affidavit of Good Moral Character has been submitted to the DJJ Background Unit prior to the January 31 deadline.

**1.02: Provision of an Abuse Free Environment**

Limited Compliance

The agency posts general information about the Florida Abuse Hotline in common areas throughout the youth shelter. Abuse Hotline information is also contained in the client handbook.

This book is provided to the resident during the admission process. This reviewer assessed all reported DJJ-Central Communications Center incidents reported and all documented internal incidents. A total of nine (9) grievances were reviewed to assess issues and incidents of physical and psychological abuse, verbal intimidation, use of profanity and other related matters. Six (6) grievances contain issues that residents have related to psychological abuse, profanity or other related matters. Of these six (6), half of these cases center around one (1) specific staff member. These cases later resulted in an internal review that required management to take administrative action on this staff member that led to their eventual termination. Additional information documents that there are several grievances that indicate violations of agency’s code of conduct related to staff member use of inappropriate language and other work performance related issues.

The agency’s staff members receive a copy of the employee handbook that also includes the agency’s Code of Conduct upon hire.

The review team collected and reviewed current incidents, internal disciplinary action reviews, three (3) staff member surveys and 3 client surveys. Information reviewed regarding incidents indicate a high degree of absconding from the youth shelter, program disruption, youth behavior, and complaints against staff members. Information reviewed regarding disciplinary action revealed
two (2) staff members suspended and later terminated work for violating agency code of conduct and work performance issues. Information reviewed regarding incidents and surveys indicates that staff members feel that low morale exist among themselves and peers. In addition, staff members indicate that their current work environment has been challenging to work under. This is due to recent upper management/supervisor position changes and resignations and or terminations at both Miami Bridge shelter locations. Further, staff members added that these recent developments have resulted in less direction from management as they have had to assume multiple roles and positions that are now vacant. Staff members also report that they feel uncomfortable in participating in the staff survey process due to fear of retribution or retaliation as a result of sharing negative experiences. One youth survey indicated that the youth felt bullied by staff and feared retribution if his/her fears were made known. All other youth surveys indicated that residents feel that they are safe and they are familiar with program requirements and most basic needs are being met.

Miami Bridge leadership has an oversight process that assesses resident grievances, internal and DJJ CCC incidents. The current method of responding to issues related to complaints, grievances and incidents requires that agency management review this information and discipline eligible infractions in a timely manner. Examples of complaints indicate that the agency has an active reporting process. However, the agency internal review and response systems indicate late documentation and response(s) to address incidents involving in appropriate staff communication and another with use of force. Due to the current management vacancies, the agency’s ability to swiftly identify and address such issues is severely reduced. This issue coupled with deficiencies found in employee training records places the agency at more risk to various resident related or resident and staff related issues.

### 1.03: Incident Reporting

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The agency has a comprehensive incident reporting policy. The agency's policy specifies that the agency notifies the Department's Central Communications Center (CCC) within two (2) hours of the incident, or within 2 hours of becoming aware of the incident. The agency had a total of forty-seven (47) reportable incidents over the last six (6) months. Information from reviews was provided by the DJJ Office of Prevention and Victim Services. Access to the DJJ CCC data was provided by review team member Tom Mahoney with the Bureau of Quality Improvement. The review team accessed actual Incident reports as taken by the DJJ Central Communication Center (CCC). The agency maintains copies of all DJJ and DCF incidents reported by staff in separate binders.

Of the 47 incidents, 21 were absconds (44%), 16 were Program Disruptions (smoking, contraband, illegal substance discovery, razor discovery, bullet discovery, cell phone discovery, etc.), 5 were Youth Behavior Incidents, 3 were Complaints Against Staff, 2 were Medical and 1 Miscellaneous. Of the total number of incidents, eleven (11) were reported outside of the DJJ CCC 2 hour reporting time frame and 36 were reported within the 2 hour timeframe.

### 1.04: Training Requirements

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The agency has a training policy that requires agency staff members to address training requirements for all new hires and on-going full-time, part-time and on-call agency staff members. The agency policy was last updated in 2009. In general training policy for the CINS/FINS program should be updated to be more in sync with the current DJJ-QI CINS/FINS policies. A total of eight (8) staff members training files were reviewed to assess the agency’s compliance with the training requirements.
standard. Of these files, five (5) were new hires and 3 were on-going staff members. Documentation of training is not consistent across all new hire files. Three out of 5 new hire files have blank Orientation and Training logs with no date listed to verify when training was completed. However, these files do have an Annual Training Plan Form that is capturing specified mandatory and in-service trainings. Two (2) of the 3 files have blank orientation and training forms with no dates of completion. These files have an Annual Training Plan Form that has documented trainings in 2 out of 3 files. The agency is not using the same training, format and training hour/topic tracking systems that were used in the past. Some training documentation tools were not produced until requested. The agency did not inform the review team in advance of the review of the lack of training documentation due to attrition and transition of recently departed and hired staff members. The agency was asked to present evidence of progress toward annual training topic and hours. The master training log was presented, however, the log does not have a full accounting of hours from 2011.

As of the date of this review, some first year staff members do not have evidence that demonstrate that have completed CPR and First Aid training. The majority of new hires have time to complete required training prior to the close of each of their anniversary dates. In addition, some on-going staff members files reviewed, did not have evidence of completing CPR training.

1.05: Interagency Agreements and Outreach  

Satisfactory Compliance

The agency has an internal policy on Interagency Agreements and Outreach. The current policy is documented as last revised in July 2010. The agency interagency agreement manual was reviewed for current agreements and outreach effects. Current written agreements or Memorandums of understanding are housed in a separate binder. There is a staff person designated to coordinate and provide outreach services. The agency conducted a successful Gala event to increase public awareness and to raise funds for its programs during the first quarter of this year.

Agency community Outreach efforts are conducted upon request. A minimum of one (1) per quarter is documented. The agency list of agreements, include schools in all service area counties served by the agency, law enforcement, local schools, health, mental health, and substance abuse providers. Some interagency agreements are dated and have information that indicates that the original agreement period may have expired dates with no indication of renewal. Agreements reviewed onsite that do not appear to be current include Community Aids Resource, Inc (2009) and Camillius Health (2009), which should be reviewed for updating.

While the program provided Community Outreach as demonstrated by information provided through the FNYFS NetMIS, no documentation of targeted audience, (i.e. sign-in sheets to reflect specific activities, specific service provided and verification of actual attendees). Further, the agency should utilize more effective documentation of its outreach efforts by employing the consistent and on-going use of a sign-in sheet to documents target audience reached and the specific outreach activity conducted. It was also recommended that the agency established a minimum time frame for the lifespan of an agreement and to establish a renewal process for all expiring or expired interagency agreements.
1.06: Disaster Planning

The program has a written Emergency Preparedness/Disaster and Emergency Plan to address the requirements as listed in standard 1.06 Disaster Planning. The current policy is documented as last revised in July 2011. The agency posts maps/egress plans in the dormitory areas and at specific exit points throughout the youth shelter. The program participates in the Universal Agreement for Emergency Disaster Shelter with the Florida Network Member Agencies.

The current Emergency Disaster Plan includes Disaster Preparedness Planning. Specific types of emergencies and disasters listed include Tornado Preparedness, Bomb Threat Preparedness, Terrorist Acts, Youth Riots, Taking of Hostages and Hazardous Waste. The program has a comprehensive Emergency Response Plan that is reviewed by the FNYFS annually. The Disaster and Emergency Plan includes: 1) all of the required types of emergency situations; 2) evacuation sites for the shelter; 3) meeting sites on the outside of the building in the event of evacuation; 4) evacuation routes to ensure safe and secure transportation; 5) checklist of all appropriate and necessary equipment; 6) staff contact list; and 7) notification procedures to the Florida Network. The emergency plan also includes procedures to address bringing necessities during and evacuation and the process of notifying the Florida Network office.

The Hurricane Team sign-up sheet needs to be update. The current sheet appears to have staff signed up for providing care and supervision during and after hurricanes. Current sign-up sheets includes a mixture of staff members from both the Miami and Homestead youth shelters.

Standard 2: Intervention and Case Management

Overview

Miami Bridge Youth and Family Services is contracted to provide both shelter and non-residential services for youth and their families in Miami-Dade County. The program provides centralized intake and screening twenty-four hours per day, seven days per week status offenders that include runaways, truants, ungovernable and lockout youth. Trained staff members are available to determine the needs of the family and youth. Residential services, including individual youth, family and group services. Case management and substance abuse prevention education are also offered. Aftercare planning includes referring youth to community resources, on-going counseling and educational assistance.

At the time of this review, according to agency’s organizational chart lists John Piedrahita, MS as the Director of the Miami Site and Clinical Services, Mary Behr, MS, Director of Community Base Services, Regina Vendrys, LMHC (contractor), Cheryl Polite Eaford, LCSW (contractor) and six (6) counselors. John Piedrahita, Director of Miami Site and Clinical Services also manages a case load of clients and oversees all direct care staff and recreational activities.

The counselors are responsible for providing case management services and linking youth and families to various community services. The First Stop non-residential program is responsible for coordinating the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The component of
the agency also recommends the filing of a CINS Petition with the court as needed.

As needed, Central coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court.

### 2.01: Screening and Intake

Satisfactory Compliance

A total of six (6) youth files (3 residential and 3 non-residential) reviewed to assess the agency’s adherence to the requirements listed under 2.01 Screening and Intake. All referrals received through shelter or non-residential programs are screened for eligibility with seven (7) calendar days of referral by a Bachelors/Masters level staff member using the NetMIS screening form.

Files reviewed under this standard indicate youth and parents/guardians received the available service options; rights and responsibilities of youth and parents/guardians information and parent youth brochure. Files reviewed contain a copy of the form indicating that this information was shared with youth and parents/guardians. Staff members provided the reviewer of this standard with a copy of the program’s Parent Handbook provided to youth and parent at Admission/Intake. The handbook includes information and instruction on the grievance process. The Introduction to Services for Miami Bridge includes: Your Rights as a client; HIPPA Compliance and Interagency Disclosure of Health and Mental Health Information; Purpose of Visit (Available Services Options); Responsibility as a Client; Client Grievance Policy; and Procedure and Reporting.

Further, all files have evidence that verify with signatures that explain youth rights and responsibilities, how to receive services, release of confidential information, grievance procedures, and other relevant program information. Parents receive brochures on the agency’s other programs and a brochure on parent options for ungovernable children and possible actions occurring through involvement with CINS/FINS services. The brochure also includes information about the Case Staffing Committee, CINS Petition, and CINS Adjudication.

The majority of psychosocial assessments meet the requirement of 2 to 3 face-to-face contact after the initial intake/update for all non-residential clients. One of the 6 files was signed after the 72 hour admission requirement. Additionally, a truancy referral to the agency date 06/27/11 indicating the referral date to the agency. However, the referral date reflected on the eligibility screening/intake assessment was 09/19/11.

### 2.02: Psychosocial Assessment

Satisfactory Compliance

A review of the agency’s policy and procedures for psychological assessment was conducted and was found to be inclusive of all components required by Standard 2.02. A total of six (6) residential files were reviewed for adherence to this standard. Of these files, all possessed data to support that the agency consistently maintained information for assessments. All psycho-socials were completed on all youth receiving services. Psychosocial assessments included in all files reviewed reflect that psycho-social assessments were initiated within 72 hours of admission into shelter care with the exception of evidence found in one (1) client file.
All psychosocial assessments were completed by a Bachelor’s or Master’s level staff and included a supervisor’s review signature upon completion.

2.03: Case/Service Plan | Satisfactory Compliance

A review of the agency’s policy and procedures for case/service planning was conducted and was found to be inclusive of all components required by Standard 2.03. A total of five (5) were reviewed for adherence to this standard. Of these charts, 3 were residential and 2 were non-residential. All 5 client files reviewed had evidence of case plans that were initiated within the required 7-day time deadline from the date of the assessment; signatures of counselor and supervisor on each plan. Four (4) out of the 5 files reviewed had the needs and goals identified; service type, frequency and location identified; person responsible; target dates assigned per goal; date plan was initiated; and evidence of 30 day plan reviews. Three (3) out of the 5 had evidence of signatures of youth and parent/guardian on the service plan. None of the 5 service plans reviewed had evidence of actual completion dates based on target dates assigned to goals.

All goals designed lacked individualization or were similar if not the same. Goals also do not clearly address the risk identified during the screening and assessment phases, as well those identified in case notes. Some service plans list need for referrals to outside sources in the service plan. However, there was no evidence of actual referrals to outside sources found in the case notes or agency referral forms/documentation.

2.04: Case Management and Service Delivery | Limited Compliance

A review of the agency’s policy and procedures for case management and service delivery was conducted and was found to be inclusive of all components required by Standard 2.04. A total of five (5) charts were reviewed to determine the agency’s adherence to this standard. A review of the aforementioned cases found that all cases were assigned a counselor/case manager as designated by signatures for case plans, assessments and all other paperwork. Referrals were determined to be needed in 2 out of 5 cases. Evidence of actual referrals were difficult to find and to confirm that this referral was executed. Three (3) out of 5 cases demonstrate evidence of counselor coordination service plan implementation. All cases reviewed have evidence that the counselor is tracking and monitoring the youth/family progress and providing necessary support for family.

Specific details in cases reviewed indicate the case was opened on 12/15/11 and the service plan was implemented on 12-21-11. The service plan for this client dates that service plan was reviewed by all parties on 12/21/11 when the plan was implemented. Documentation in file indicates that the supervisor signed off on the plan on 01/30/2012. The first case plan review was dated 01/31/12, supervisor signed 01/30/12, 30 day review 01/19/12, supervisor signed 01/30/12. If there is one update, it is unclear what the update is and when it actually occurred. The length of time when the supervisor is signing psycho-social assessment is delayed. This is evidenced by signatures for 90 day reviews on 02/01/12 were closed before 90 days. Supervisor has signed off in service plan in February 2012, however a case plan was initiated in October 2011.

Specific entries in a client file review indicate that there are discrepancies with the dates of typed case note entries and supervisory review dates. The aforementioned client’s file indicates that the supervisor is review date (02/12/12) on this file is signed prior to the actual date that the counselor's
case note entry (02/22/12). Other review case note entries indicate that the supervisor is review date (02/27/12) on this file is signed prior to the actual date that the counselor’s case note entry (03/03/12). An additional case note indicates that the supervisor is review date (02/27/12) on this file is signed prior to the actual date that the counselor’s case note entry (03/05/12). No other case files had evidence of the aforementioned inconsistencies.

2.05: Counseling Services

Limited Compliance

A review of the agency’s policy and procedures for Counseling Services was conducted to determine adherence to all by Standard 2.05. A total of five (5) client files were reviewed for adherence to this standard to assess if youth/families receive counseling services in accordance with the service plan. Of the 5 files reviewed, there are 3 open residential files and 2 closed non-residential files. The 5 files reviewed indicated that there were service plans in 4 files that coincide with the counseling services being provided by the agency. Of these files reviewed, Specific details in a case opened on 09/19/11, client was not seen until 10/13/11, Client refused to meet (client refused to meet). On 11/17/11 client’s Mother called and state that the client was arrested. There is no documentation in the file to indicate any follow up by the agency between 10/13/11 and 11/07/11. Documentation in client file indicates that the case was closed on 01/04/12. There is no evidence of entries in the file between 11/07/11 and 01/04/12.

Of these files, all 3 of 5 have evidence of youth and families receiving counseling services in accordance with the case/service plan. Four (4) of 5 have evidence that the program provides individual/family counseling in shelter care. All three (3) residential files have evidence of group counseling at least 5 days a week. The shelter does maintain a logbook of the group sessions that are conducted. One (1) of 2 applicable cases have therapeutic community-based services for non-residential services. All 5 case evidence that the youths presenting problems are identified and also listed in the psycho-social assessment. Four of 5 have evidence of initial case/service plans. Four of 5 have evidence of service plans, but signatures, review dates and other information is not consent (see 2.03). Case notes list basic information in many cases and some case files lack consistent entries and supervisor review discrepancies. There is an on-going process of the internal review of case files that require clinical reviews of case records.

2.06: Adjudication/Petition Process

Satisfactory Compliance

A review of the agency’s policy and procedures for the adjudication/petition process was conducted and was found to be inclusive of all components required by Standard 2.06. One case staffing case file was provided by the agency for review that opened on 09/19/11. Documentation provided by the agency indicates that notification of the staffing to the family and the committee was less than 5 working days prior to the staffing. Staffing lacked representation from school board, DJJ representative, State Attorney’s Office and representatives from mental health, substance abuse, law enforcement, DCF and other representatives. At the time of this review, this case did not provide evidence of case staffing proceedings, subsequent plans of service, written case staffing meeting summaries and recommendation. There was no evidence to determine if further judicial intervention (petition) was required or took place or if a review summary was completed by a counselor prior to review.

The program has formal procedures documented for the case staffing process. The procedures address all elements of the indicator and require the case staffing to be held within seven days of
the parent/guardian's request. However, the program does not have an established Case Staffing Committee or formal process for scheduling meetings on a regular basis. It was not possible to ascertain additional practice for this indicator since there was only one (1) case provided for this review. The agency reports that there has not been any additional formal requests made during the past six months for CINS Petition.

**Standard 3: Shelter Care/Health Services**

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Miami Bridge is licensed by the Department of Children and Families (DCF) for twenty-eight (28) beds and it primarily serves youth from Miami-Dade County. The shelter also provides services to youth referred to them from the Department of Children and Families. The shelter building includes a large day room, girls and boys dormitories, dining room, kitchen, laundry, staff offices and a conference room. During the quality assurance review, the shelter was found to be in good condition and the furnishings in good repair, and the rooms and common areas were clean. The dormitory is divided into two separate areas, one for the boys and one for the girls. There are 2 bathrooms on each dorm wing. The sleeping rooms house fourteen (14) youth each; each youth has an individual bed, bed coverings and pillows. In addition, the youth have access to a recreational games, volley ball court and basketball. This youth shelter is designated by the Florida Network of Youth and Family Services to provide staff secure services.

Staff members assignment to mainly residential duties include Other staff members include nineteen (19) Direct Care staff members, a Health care specialist, a Shelter Coordinator, a MIS Specialist and a Facilities Coordinator. The Direct Care workers are responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision.

The youth care workers are responsible for processing new admissions, and providing orientation of youth to the shelter; the supervision of youth; and for maintaining inventories on all sharps and medications. Youth care workers also assist in the self-administration of prescribed and over-the-counter medications, and administer first aid when needed. Disaster plans, knife-for-life, wire cutters, and first aid kits are located in multiple locations throughout the facility, to include the staff station, medication room, and kitchen. All medications are stored in a locked cabinet in the direct care staff office. The program’s behavior management system consists of three (3) levels (Orientation level, Level 1 and Level 2). Youth start on the orientation level and advance up or down the levels depending on the total number of points accumulated each day; and privileges are based on the youth’s level.

Oversight of clinical services is provided by the John Piedrahita, MS, Director of the Miami Site and Clinical Services. Licensed staff are contracted and there is a Licensed professional assigned to each program site. Youth admitted to the program are screened using the CINS/FINS Intake Form. If a youth answers “yes” to any of the six questions pertaining to suicide risk on the CINS/FINS Intake form, an Assessment of Suicide Risk is completed. A medical and mental health alert system is in place.
3.01: Shelter Care Requirements

A review of the agency’s policy and procedures for screening and intake was conducted and was found to be inclusive of all components required by Standard 3.01. The agency is not a staff secure program per their contract with the Florida Network of Youth and Family Services.

A total of six (6) open CINS/FINS residential client files were reviewed to assess this indicator. Of these files, all client files have evidence of each resident receiving a comprehensive orientation with the 24 hours time requirement following admission. All case files reviewed have evidence that residents received Youth Rights information, Grievance Procedure and a cross section of process information. Specifically, the youth receive a handbook that outlines their rights and responsibilities and formal grievance process, which are also posted on a bulletin board in the common area, as well as program rules and expectations. The grievance is posted in plain view in the day room and the box is full with blank forms.

The agency has an overnight bed check policy. The current policy requires that all resident bedrooms and residents be admitted to the youth shelter be checked via visual observation and documentation of no more than 15 minutes. The agency requires that all overnight staff members conduct bed checks thorough the overnight work shift. A review of agency documentation for eleven (11) randomly selected overnight work shifts was selected. Each individual bed check is conducted by the Youth Care Worker on duty. The monitor reviewing this indicator reviewed bed check shift logs from October 2011 through January 2012. At the time of this onsite review, all bed check documentation reflects a consistent accounting of count on average less than 13 minutes on the overnight shift. Bed checks are not written in real-time. Bed check entries are documented between 10-15 minute intervals such as 12:00 am, 12:15am and 12:30am. In addition, the schedule reflects compliance with at least one male and one female staff member is scheduled to work on each overnight shift.

It was not possible to ascertain additional practice for this portion of this indicator since there were not court ordered Staff Secure Cases for the standard. The agency reported that no courted Staff Secure youth have been sent to the agency in over a year.

3.02: Healthcare Admission Screening

The program had written procedures for Healthcare Admission Screening (Physical Health Screening). A review of the current policy found that the policy included all the elements required in the indicators.

A review of six (6) individual youth case files (3 shelter and 3 non-residential) found that in all cases reviewed the program completed a CINS/FINS Intake Assessment form that included all the required elements of the indicator. Documentation verified that the program verifies all medical referrals on a daily log.

During the Staff Orientation Program applicable staff members are trained on the Health Care Admission Screening form and the Suicide Risk Assessment Tool.
3.03: Suicide Prevention  
Satisfactory Compliance

The program had written policies and procedures related to Mental Health, Substance Abuse and Suicide Risk Screening and Suicide Assessment.

A review of individual case files confirmed that the program screened youth for suicide risk at all cases at admission. The suicide screening results were reviewed and signed by a supervisor and documented in the youth's file.

Three (3) additional closed files were reviewed and youth that demonstrated a suicide risk were placed on the appropriate level of supervision.

3.04: Medications  
Satisfactory Compliance

The program had written procedures for the storage, access, inventory, administration, documentation and disposal of medications. The program procedures encompassed all the mandatory components of the indicator.

Observation confirmed that the shelter stored medications in the Intake Office and the Healthcare Specialist Office. The medications located in the Intake Office were for the daily use of the youth in the program. Bulk storage was located in the Healthcare Specialist Office. Medications were maintained in a locked cabinet and in a locked medication cart. Oral medications are not stored with injectable or topical medications.

The program did not have any medications that required refrigeration, although the program maintains a special refrigerator available for medication only.

The program had a list of staff trained and approved to administer medication to clients.

3.05: Medical/Mental Health Alert Process  
Satisfactory Compliance

The program had a procedure entitled Medical and Mental Health Alert Process, that ensured the youth's information related to medical and mental health conditions are documented. The program has a color coded alert system that was communicated to staff through the program logbook, the alert board located in the Intake Office, and documented in the youth's individual case file. The Client Alert System identified medical, substance abuse, victimization, nutritional and mental health issues.

A review of the Special Nutritional instructions binder located in the kitchen documented any food allergy issues.

A review of the program logbook indicated that not all staff consistently documented that they reviewed the program logbook on each shift to verify an awareness of current alerts. In addition, the current method that the agency informs the next shift of major issues is lacking and does not effectively inform follow shifts of past events and activities that have previously occurred. The agency needs to develop a more effective method of documenting critical information form shift to shift.
The program had written procedures for Emergency Mental Health and Substance Abuse Services. A review of the Emergency Drills Log confirmed that program consistently conducted emergency/First Aid drills on all shifts on a monthly basis. For each mock drill conducted, the program completed a detailed Emergency Drill report, which critiqued the event.

A review of documentation revealed that the program utilizes Jackson Memorial Hospital for emergency medical care and Citrus Health Network for mental health/substance abuse referrals. Documentation confirmed parental notification whenever episodic/emergency care events took place.

Observations confirmed that knife-for-life and First Aid kit/supplies were located in the school, First Stop office, the 2 program transportation vans, the Healthcare Specialist office, and the Intake Office.

A review of staff training files could not verify that all applicable staff members received the necessary training for episodic/emergency care in the following topics: Crisis Intervention, Suicide Prevention, Signs and Symptoms of mental health/substance abuse, and Universal Precautions.

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<tbody>
<tr>
<td><strong>Satisfactory Compliance:</strong></td>
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