



# **Florida Network of Youth and Family Services Quality Improvement Program Report**

Review of Miami Bridge-Homestead

on 10/22/2014

## CINS/FINS Rating Profile

### Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory

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

### Standard 3: Shelter Care

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

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

### Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Psychosocial Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory

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

### Standard 4: Mental Health/Health Services

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

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

## Overall Rating Summary

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

### Rating Definitions

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

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

### Review Team

#### Members

Marcia Tavares, Lead Reviewer, Forefront LLC

Ivonne Fusco, Senior Administrative Assistant, Lutheran Services Florida Southeast

Bill Mann, Interim Executive Director, Florida Keys Children's Shelter



Gabriel Medina, Program Monitor, Department of Juvenile Justice

Jamie Shine, Case Manager, Urban League of Palm Beach County

**Persons Interviewed**

- |  |                          |                         |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 1 Case Managers          | 1 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor                 | 6 Clinical Staff         | 2 Program Supervisors   |
| <input type="checkbox"/> DHA or designee             | 1 Food Service Personnel | 0 Other                 |
| <input type="checkbox"/> DMHA or designee            | 1 Health Care Staff      |                         |

**Documents Reviewed**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports                        | <input checked="" type="checkbox"/> Fire Prevention Plan             | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records        | <input checked="" type="checkbox"/> Visitation Logs            |
| <input checked="" type="checkbox"/> CCC Reports                       | <input type="checkbox"/> Key Control Log                             | <input checked="" type="checkbox"/> Youth Handbook             |
| <input type="checkbox"/> Confinement Reports                          | <input checked="" type="checkbox"/> Logbooks                         | 3 Health Records   |
| <input checked="" type="checkbox"/> Continuity of Operation Plan      | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 3 MH/SA Records  |
| <input checked="" type="checkbox"/> Contract Monitoring Reports       | <input type="checkbox"/> PAR Reports                                 | 13 Personnel Records   |
| <input checked="" type="checkbox"/> Contract Scope of Services        | <input checked="" type="checkbox"/> Precautionary Observation Logs   | 7 Training Records/CORE  |
| <input checked="" type="checkbox"/> Egress Plans                      | <input checked="" type="checkbox"/> Program Schedules                | 10 Youth Records (Closed)                                      |
| <input type="checkbox"/> Escape Notification/Logs                     | <input checked="" type="checkbox"/> Sick Call Logs                   | 10 Youth Records (Open)  |
| <input type="checkbox"/> Exposure Control Plan                        | <input checked="" type="checkbox"/> Supplemental Contracts           | 0 Other  |
| <input checked="" type="checkbox"/> Fire Drill Log                    | <input checked="" type="checkbox"/> Table of Organization            |  |
| <input checked="" type="checkbox"/> Fire Inspection Report            | <input type="checkbox"/> Telephone Logs                              |  |

**Surveys**

- |         |                     |         |
|---------|---------------------|---------|
| 3 Youth | 3 Direct Care Staff | 3 Other |
|---------|---------------------|---------|

**Observations During Review**

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

**Comments**

Items not marked were either not applicable or not available for review.

Rating Narrative

## **Strengths and Innovative Approaches**

### Rating Narrative

Miami Bridge Homestead (MB Homestead), located in the city of Homestead in southern Miami-Dade County, 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 is currently accredited by the Council of Accreditation (COA) and recently received re-accreditation through August 31, 2017. The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards.

MB Homestead's administrative office is located in North Miami, Florida, along with its north CINS/FINS shelter. The program serves both 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 emergency shelter offers a variety of services to meet the need of its target population. These services include: 24 hours a day, seven days a week shelter services; formal on-site education program with certified Miami-Dade County Public School teachers; structured daily living programs employing positive behavior modification techniques; mental health counseling; life skills groups to promote responsibility and independence; substance abuse prevention services; family reunification services and case management; positive youth development through recreation, arts, crafts and music; and health care coordination services to insure access to medical treatment.

Miami Bridge employs professionally licensed staff for both mental health and medical services. Its licensed Mental Health professionals provide oversight over its counseling services in both the residential and non-residential CINS/FINS programs at both program location in Miami and Homestead. In addition, there is a Licensed Practical Nurse on site to oversee the referral for health care services and medication management of youth in care.

MB Homestead has established partnerships with various businesses and receives support in the form of in-kind donations, volunteer services, and community funding. Since the last onsite monitoring visit, MB Homestead has made improvements to the facility and grounds. The provider added a new electric fence around the grounds and installed new cameras as well as a new Air Conditioning system in the on site school building. The provider also received \$200,000 funding through the CRA and Community Development Block Grant to improve the physical structure of the facility in Homestead. During the QI visit, the facility was undergoing construction in the form of new hurricane impact windows and doors, and recent re-painting of the facility. Future renovations are planned to redo the bathrooms as well as improve the overall structure and appearance of the facility.

Recently, the Book of Leaders, known as Miami's Hall of Fame, recognized Miami Bridge's own Mary Andrews, CEO, and Board Member Boo Zamek for being a part of Miami's Leaders 2014 in its September 29<sup>th</sup> issue. Each year's book profiles 52 Newsmakers and Achievers and Miami Bridge is honored to be among these prominent leaders.

## Standard 1: Management Accountability

### Overview

#### Narrative

MB Homestead, located at 326 NW 3rd Avenue, Homestead, Florida, is under the leadership of a Board of Directors, Executive Director, Chief Operations Officer, Chief Financial Officer, Chief Quality Improvement Officer, and Chief Clinical Officer. Mary Andrews, Executive Director oversees the Miami Bridge program and the services provided through its two (2) service locations in Central Miami and Homestead, Florida.

The residential component of the Homestead program is managed by a Shelter Director as well as Shift Leaders on each of the three shifts. The clinical component was recently under the supervision of a Director of Clinical Services but that position became vacant five days prior to the Central Program's QI Review held October 8, 2014. In the interim, clinical supervision is the responsibility of the Chief Clinical Officer. At the time of this Quality Improvement review, the program had a full complement of staff. The MB Homestead facility is licensed by the Department of Children and Families for 20 beds, with the current license in effect until February 28, 2015.

The agency handles all personnel functions for its two service locations through its Human Resources division located at the Central office in Miami, Florida. This office processes all state and local background screenings and human resource functions including staff development and training. 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 and an attendance form. The provider agency conducts orientation training to all personnel through a combination of training sources that include the Florida Network, local area and in-house trainers.

The program's Emergency Response Plan was revised in April 2014. A copy of the plan was reviewed on site. A Universal Agreement for Emergency Disaster Shelter is also in force and was signed by the agency's Executive Director.

### 1.01 Background Screening

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy and procedures in place that address the background screening of all employees and volunteers prior to any offer of employment or service. The policy requires all staff and volunteers to complete a DJJ Background Screening in accordance with FS 985.407 that includes good moral character documentation, criminal history background screening and electronic submission of Department of Homeland Security E-verify for new employees confirming work eligibility. In addition, the provider conducts a drug screening and conducts a local law enforcement check, a driving history check with the Division of Motor Vehicles, and pre-employment TB test prior to the hiring of all staff.

A total of eight (8) applicable personnel files were reviewed for five (5) new staff, two (2) volunteers, and one (1) staff eligible for 5-year re-screening. The five (5) new staff were hired after the last onsite QI visit and all five received eligible screening results that were conducted by the Department of Juvenile Justice (DJJ) Background Screening Unit prior to hire. Similarly, the one staff that was eligible for a 5-year re-screening had the re-screening conducted within the required timeframe prior to the staff's five-year anniversary date.

The program has two (2) volunteers providing service during the review period. Both volunteers received eligible screening results from DJJ prior to their service start dates.

In addition to the DJJ Background Screening, the agency also requires employees to pass a drug screening and conducts local law enforcement check, a driving record history check, and verifies previous employment history, and contacts up to three references. Electronic submissions of Department of Homeland Security E-verify for the 5 new employees were verified, confirming the employees' work eligibility.

Exception:

The Annual Affidavit of Compliance with Good Moral Character Standards was completed on January 3, 2014. Email notifications of the Annual Affidavit of Compliance with Good Moral Character Standards were sent to the Florida Network and to the DJJ Contract Manager; however, a copy was not sent to DJJ's Background Screening Unit (BSU) as required. Upon notification during the onsite review at the Central location on October 8, 2014, the provider submitted its Annual Affidavit of Compliance with Good Moral Character Standards to the DJJ BSU.

### 1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

#### Rating Narrative

The Agency has a current policy and procedure in place for the provision of an Abuse Free Environment. The policy requires all employees to immediately report all allegations of child abuse or suspected child abuse to the Abuse Hotline. Staff are trained in these procedures during their first year of employment on how to report Child Abuse. In addition, agency has a Code of Conduct, Dress Code policy, Grievance Process, Drug-Free Workplace policy and Whistleblower policy to provide a safe place for its employees and clients.

During the tour of the facility the Reviewer observed posters with House Rules and Guidelines, Youth Rights and Responsibilities, Emergency Numbers and Evacuation Procedures in the hallway as well in the dorm rooms. There is some graffiti on the beds. A Grievance Box and binder are kept and a Monthly Abuse Registry Log and a Client Grievance Monthly Log are kept as well. During the last year there was 1 (one) abuse reported but the section to be completed by the client's assigned Residential Counselor was not fully completed.

Regarding grievances, all clients receive an Orientation Guide with Grievance policy, procedure and report form during admission. A confidential grievance box and forms are accessible to youth in the facility. In the past six months there were 8 (eight) grievances with final resolution and management review. The three youth who were surveyed during the QI Review knew about the abuse hotline and grievance process and indicated they feel safe at the shelter.

No exceptions to this indicator were noted at the time of the visit.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

#### Rating Narrative

The Agency has a written policy and procedures on Incident Reporting with a detailed practice on how to proceed for different type of incidents. The provider's policies comply with the procedures and guidelines of the Quality Improvement indicator and the Florida Network's policies and procedures.

In a review of the CCC incident documentation for the past six months, there were 8 (eight) incidents (one medical, five runaway and two contraband) reported between 4/1/14 - 10/20/14; all incidents were called in within the two hour frame required.

This reviewer acknowledges that all documentation is very well maintained and there is an excellent practice in place.

There are no exceptions to this indicator at the time of the visit.

### 1.04 Training Requirements

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy outlining Training Requirements for the first year of employment and for In-service staff. The policies comply with the requirements and procedures outlined in the Florida Network's Policy and Procedures and by the Quality Improvement indicator.

There were 3 (three) First Year Training files reviewed. All are missing Fire Safety training (required for all staff) and Title IV-E (residential staff). The provider's Policy and Procedure 1.04, pages 2 and 3, lists training topics the agency states it will provide. Neither Title IVE nor CPR/First Aid is included on the agency's training list, although they are both mandatory trainings. In addition, the provider's training list shows HIV/Universal Precaution and Cultural Diversity trainings to be included in new/in-service staff training. None of the three new hire staff had received those trainings as of the date of the review; however, the staff still have time until 2015 to complete those training requirements.

There were 5 (five) In-service training files reviewed; one is missing Fire Safety Equipment and three are missing Universal Precaution and

Cultural Competency. Although Universal Precaution and Cultural Competency trainings are not QI training requirements, the provider's policy includes them for new and in-service staff.

Regarding Training in Assessment of Suicide Risk for Non-licensed Mental Health Clinical Staff, the two new staff need to be trained and forms need to be filled out and signed.

The program maintains an individual training file for each staff that includes an annual tracking form and all related documentation as certificates and sign-in sheets

Exception:

Three of the provider's staff did not receive Universal Precaution and Cultural Competency trainings in the most recently completed training year or in the current training year-to-date as required by the provider's training policy.

The two new Non-licensed Mental Health Clinical staff, DOH 6/30/14 and 8/12/14, do not have any documentation of training received in the Assessment of Suicide Risk. The forms, entitled "Documentation of Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide", were found in the staff's personnel files but did not show completion of any supervised assessments.

### 1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a written policy and procedures for Analyzing and Reporting Data for Case Record Review; Incidents, Accidents and Grievances; Customer Satisfaction; Outcome Data and Netmis Data. It's the responsibility of the Chief Quality Improvement Officer and the QI Manager to oversee and coordinate the activities of the Committees.

In August 2013 Miami Bridge was re-accredited by the Council on Accreditation. In practice, the following Committees and meetings were held monthly: Clinical Staff, Risk Prevention, Staff Meeting, and Manager's Meeting. Quarterly Meetings were held by the following committees: Case Record Committee, Satisfaction Survey Committee, Outcomes Review, Netmis Review and All Staff Meeting.

The Steering Committee meets on quarterly basis. The members include staff from both programs that review data and reports from all Committees and Subcommittees. They assess data and discuss findings and activities to fix any issues that need corrective actions. Netmis data and Benchmarks from the Florida Network are also reviewed on a monthly basis and reports progress to the management team.

A review of the last Quarterly CQI Committee Meeting held in September 2014 included key information about Committees and Subcommittees data and reports. The minutes and agendas include a detail description of all the findings with critiques and plans to correct them.

## Standard 2: Intervention and Case Management

### Overview

#### Rating Narrative

Miami Bridge Homestead is contracted to provide both shelter and non-residential services for youth and their families in South Miami-Dade County. The program provides centralized intake and screening twenty-four hours per day, seven days per week for status offenders that include runaways, truants, ungovernable and lockout youth. The program has a Director of Admissions who is responsible for Intake and Admissions. Additionally, trained staff members are available to determine the needs of the family and youth. Residential services include individual youth and family counseling sessions as well as group education services. Case management and substance abuse prevention education are also provided. Aftercare planning includes but is not limited to referrals to community resources, on-going counseling, and educational assistance.

At the time of this review, according to agency's Organization Chart, the Chief Clinical Officer, oversees the clinical component of the program. The staff roster shows that the program employs the following direct care staff: 3 Masters Level Counselors (two- Residential and one- non-residential Counselor), one Bachelor's level Case Manager, 8 FTE Youth Activity Workers (YAW), 3 On-Call YAW, a Food Service Coordinator, and a LPN Health Care Specialist. Each shift is assigned a Shift Leader who is responsible for overseeing all of the activities on the shift, participating in team conferences, and relating shift exchange information. The counselors are responsible for providing case management services and linking youth and families to various community services.

The 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 Case Staffing Committee can also recommend the filing of a CINS Petition with the court. However, the program stated that no Case Staffing Committee meetings were requested/held since the last QI Review.

### 2.01 Screening and Intake

Satisfactory

Limited

Failed

#### Rating Narrative

Agency's policy 2.01, Screening and Intake, provides a policy and procedures that address the requirements of indicator 2.01 while including all necessary elements.

Six files were reviewed for 3 residential and 3 non- residential youth. Eligibility Screening was completed appropriately within 7 calendar days from the date of the referral in all six files. In one non-residential file, there was a 2 and 1/2 month gap of no notes or notation from the eligibility screening date of 5/2/2014 and the actual date of intake/screening of 7/25/2014. Also, in one of the residential files reviewed, the youth did not sign the Program rules and Guidelines presented in print.

A review of all 6 files revealed that youth and guardian were given information regarding service options, program brochures, a list of rights and responsibilities, case staffing option, and grievance procedures.

### 2.02 Psychosocial Assessment

Satisfactory

Limited

Failed

#### Rating Narrative

Agency's policy 2.02, Needs Assessment, provides for and reflects all the requirements of indicator 2.02.

Six files were reviewed for 3 residential and 3 non- residential youth. Psychosocial Assessments on all 6 files audited showed the Needs Assessment was initiated and completed within 72 hours in the Residential files and completed within 2-3 visits of meeting with the non-residential client and/or family. The Needs Assessments were done face-to-face and were completed by appropriate licensed staff and reviewed by their supervisor. None of the non-residential youth were an elevated risk of suicide upon completion of the Needs Assessment. However, a protocol is in place if needed.

### 2.03 Case/Service Plan

Satisfactory  Limited  Failed

#### Rating Narrative

The agency's policy 2.03 describes the program's procedure and expectation for service planning. Agency policy 2.03.01, Case Service Plan (Implementation, Review and Revision), provides for and supports the requirements of indicator 2.03.

A total of six files were reviewed for three residential and three non-residential youth. The 3 Residential files had case service plans developed within the 7 day criteria of completion of the needs assessment. The case plans were individualized to youth's needs and goals were identified and agreed upon by all parties and signed by parent, youth, counselor and supervisor. Also noted were the frequency of services to be provided, the date the plan was initiated, and target dates. Completion dates were not due because the cases were recently opened and the goals were not yet reached. Level of progress achieved was noted after the first 15 and 30 days, respectively.

Similarly, the case plans for the 3 non-residential files were all developed within the 7 day mandated criteria. Each file was individualized and prioritized to each client, depending on issues and needs. Frequency and persons responsible were initialed and signed. However, 2 of the 3 files did not show completion dates for goals completed. Level of progress was recorded and signed off by appropriate staff.

### 2.04 Case Management and Service Delivery

Satisfactory  Limited  Failed

#### Rating Narrative

Agency policy 2.04, Case Management and Service Delivery, provides for and reflects the requirement of Indicator 2.04. The agency's policy further describes in detail the agency's protocol for meeting this requirement.

A total of six files were reviewed for three residential and three non-residential youth. Each youth was assigned a Counselor/case manager. This practice was supported by the 3 youth who were surveyed who indicated knowledge of their Counselor. The 3 residential case files reviewed had case plans that were implemented and monitored for progress. It was evident that the Counselor provided continued support to youth and family through referrals to outside agencies for additional assistance when needed. These referrals were coordinated for services that met the youth/family's needs.

The 3 non-residential files reviewed also showed assignment of a counselor who: 1) completed referrals based on needs of client and family; 2) provided on-going support; 3) coordinated service plan implementation; and 4) monitored and documented the progress of client and family. The assigned clinical staff accompanies youth to court/appointments if necessary and monitors the case.

### 2.05 Counseling Services

Satisfactory  Limited  Failed

#### Rating Narrative

Agency policy 2.05, Counseling Services and Family Involvement, provides for and reflects the requirement of Indicator 2.05. The provider's policy requires that non-residential programs provide therapeutic community based services designed to prevent involvement of youth and families in the delinquency and dependency systems. Services are provided in the youth's home, a community location or the local provider's counseling office.

A total of six files were reviewed for three residential and three non-residential youth. The 3 residential youth and family are receiving counseling services within the shelter in individual and family setting as well as group counseling. Upon review, the Group Counseling participation log book is very dense and cluttered. It was very difficult to find where the current year's participation logs were documented as they weren't being kept

sequentially by year. Youth needs from the psychosocial, case/service plan and reviews are being addressed and progress is being documented. Case notes are being maintained and documented. In addition, clinical reviews are being done.

The 3 non-residential youth files showed the youth and families were receiving the necessary counseling services and were referred when applicable to outside agencies if they were not already receiving counseling services from other agencies. Each youth and family's issues and problems were being addressed in the case plan, needs assessment and case action plan reviews. Case records were being reviewed by professionally licensed clinician. Case notes were neat and well-prepared by the counselor and well documented in chronological order.

## 2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

### Rating Narrative

The agency has a system in place outlined in their Policy and Procedures Manual explaining the Case Staffing process. Practice could not be evaluated since no case staffing committee meetings have been held during the past year. However, staff is aware of the procedures and requirements and have documented their efforts to communicate with the members of the Case Staffing Committee.

Miami Bridge has implemented a binder to keep track of all CINS/FINS Petitions. The QI Indicator, 2.06 CINS Adjudication and Petition Process, Policy, Procedure and Practices was placed in the front of the binder to show what measures are taken when a youth meets that CINS/FINS criteria. Once a request is made, First Stop for families coordinates the staffing for the process.

There is evidence of communication by the Clinical Director monthly via emails to representatives of the school district informing them of pending staffing for cases of youth who meet the CINS/FINS petition criteria. The Program has an established case staffing committee and has regular communication with committee members from the school district have been completed. Case Staffing is held on a monthly basis if there are youth who meet the CINS/FINS criteria. The schedule is: every 2nd Thursday at the Homestead Location from 1:00 pm until 3:00pm and every 3rd Thursday at the central location from 9:30 A.M. until 11:30 A.M.

As of October 2014, there is no completed case staffing. In April 2014, one was scheduled for May 8th but was canceled. There was one scheduled for October 16th but it too was canceled. It was not noted in the Petition Binder why the case staffing was canceled or if it will be rescheduled and, if so, when.

## 2.07 Youth Records

Satisfactory

Limited

Failed

### Rating Narrative

Agency policy 2.07, Youth Records, provides a protocol that addresses the requirement of indicator 2.07.

Overall all files, the 3 non-residential files and the 3 residential files, were marked confidential and kept in a locked secure room in a locked file cabinet accessible to program staff. Each file was organized according to the assigned counselor. The files were neat and orderly and easily accessible to staff.

Active files were placed in the 2 top drawers of file cabinet and all closed files are placed in the 2 bottom drawers of file cabinets. However, the file cabinets were not marked confidential on the outside.

## Standard 3: Shelter Care

### Overview

#### Rating Narrative

Miami Bridge Homestead Shelter program provides temporary residential shelter care for male and female youth identified to be at-risk. The facility is comprised of three buildings: the main shelter building, a classroom building and the First Stop For Families building for non-residential counseling. The shelter is currently licensed by DCF as an emergency shelter for twenty beds. The program has adequate space for all activities and is equipped with one dormitory for male youth and one for female youth. The dormitories, kitchen, restrooms and common areas were clean during the tour of the facility. Each dormitory is further differentiated into Module A and Module B which is used to classify youth based on risk factors identified during intake. Youth are assigned lockers to store their personal belongings. Beds and lockers are numbered and youth are assigned to individual beds furnished with bed coverings and pillows. Youth have access to a large yard for outdoor activities.

Staff members in the Residential Program include: Director of Admissions, 2 Residential Counselors, Youth Activity Workers, a Health Care specialist, a Food Specialist/Cook, and a Facilities Coordinator that is shared between the two shelters. The Direct Care workers are responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision. The Youth Activity Workers are also responsible for processing new admissions, providing orientation of youth to the shelter, and supervision of youth.

Health and medication related activities are the responsibility of the Licensed Practical Nurse who maintains inventories on all sharps and medications, provides distribution of prescribed and over-the-counter medications, administer first aid when needed, and coordinates all offsite appointments to medical providers. 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 office, and kitchen. All medications are stored in a locked cabinet in the staff office.

Oversight of clinical services is provided by Chief Clinical Officer. All youth admitted to the program receive a copy of the Client and Parent Handbook and an orientation to the facility. The program provides individual, group and family counseling, as needed. Group sessions are conducted five times per week and include: anger management, substance abuse prevention, nutrition, life skills, and social skills. Youth also received formal on-site education from Miami-Dade County Public Schools teachers and tutorial services. The program encourages family members to visit and to take part in the development of the youth's service plan. The program utilizes a variety of local medical facilities for emergency services. The shelter also admits youth from the Department of Children and Families (DCF). The shelter is designated by the Florida Network to provide staff secure services, Domestic Violence Respite, and Probation Respite.

### 3.01 Shelter Environment

Satisfactory

Limited

Failed

#### Rating Narrative

The Homestead shelter is a residential program for both youth who meet the criteria for CINS/FINS as well as youth who are referred by the Department of Children and Families.

During the tour of the facility, the building appeared to be clean and well maintained despite its age. The provider shares a Maintenance staff between its two locations and it appears that the maintenance staff does a good job in maintaining the building and grounds. The facility has a large lounge used for resident meetings and a space for youth to relax during downtime. The facility also has a separate area for dining and a large commercial kitchen equipped with a large freezer and two refrigerators, one for the youth and one for staff. The Youth Care Intake office sits next to the lounge and has clear windows to ensure continuous view of the youth. A small space to the rear of the lounge is equipped with a television, video games, and a bookshelf.

The counselors and staff offices are located on the periphery of the lounge and along one hallway that leads to the girl's dorm. Additional rooms in the facility include a family meeting room, a laundry room, and a Nurse's station. There are separate dormitories for the male and female residents. Each dorm area is furnished with 5 new bunk beds; new comforters and pillows that were recently donated; individual youth lockers; a loveseat; postings of rules, rights and responsibilities, expectations, important telephone numbers; and posters. Vertical blinds adorn the windows and provide youth with privacy. Each bathroom includes: 3 showers, 3 dressing rooms, and 3 sinks. The grounds were well manicured and landscaped. The provider recently added a new 27-digital camera security system with web-based monitoring and infrared features. All of the cameras were operational during the visit.

During the tour, eight fire extinguishers were strategically located throughout the building and they were all updated with same expiration dates of June 2015, with the exception of the one in the kitchen which is valid through September 2015. The agency's annual Fire Permit was conducted by the Miami Dade Fire Rescue on 2/18/14; no violations were found. The Range Hood in the kitchen was inspected on 9/30/14. The Sanitation certificate from the Florida Department of Health was up-to-date and expires on 09/30/2015. In addition, the Department of Health conducted satisfactory quarterly Food Inspections on 5/13/14, 8/11/14, and 9/22/14 as well as a semi-annual Group Care Inspection on 3/5/14. A current Medical Waste Inspection Report effective through 5/13/14 was posted in the kitchen. The Department of Children and Families issued the agency's Child Caring License for 20 beds on 3/1/14 with an effective date through 2/28/2015. At the time of the review, the program had 14 youth, 6 females and 8 males, in the shelter.

During the tour, the youth were participating in school. The facility has its own building used for school which is separate from the main living

area. The atmosphere was conducive for learning and instructions were provided by two certified Miami Dade instructors. The facility also has a Youth Care Staff who coordinates structured activities for the youth.

Two week cycle food menus were approved through 6/30/15 by a licensed Dietician and were posted in the kitchen. The program's licensed Dietician license expires 5/31/15.

Monthly Fire Drills were performed consistently, once on each shift. The provider maintains excellent records of the fire drills which include a critique by the Residential Manager and various simulations. All of the drills reviewed since April 2014 were completed in less than 2 minutes. Emergency drills were conducted in accordance with policies; there was a minimum of one mock emergency drill each month.

Exceptions:

- 1) Emergency Disaster Plan contact sheet (last revised April 2014) is not up-to-date and has staff who are no longer employed listed.
- 2) Graffiti was observed on several of the beds in the girl's dorm on beds #1, 2, 3, 4 and 6 and on boy's bed #4.
- 3) The area around the a/c ceiling vent in the center of both the girl's and boy's dorm room is cracked and peeling
- 4) Interior of 2 vans inspected are in disrepair with torn roof, torn seats, and damaged flooring. One of the vans has graffiti on the roof and seatbelt. The provider has been approved to receive two new vans and will be replacing the 2005 Blue Ford E350 and the 2004 Silver Ford vans in the near future.
- 5) Lint was observed on wall above the postings in the girl's dorm.

### 3.02 Program Orientation

Satisfactory                       Limited                       Failed

#### Rating Narrative

The agency has Orientation Policy and Procedures that covers details of the youth stay at the shelter such as program philosophy, goals, services, and expectations. The orientation ensures that each youth is given a list of contraband items, and that each youth is informed of: disciplinary actions; program's dress code; access to medical and mental health services; procedures for visitation, mail and telephone; grievance procedure; disaster preparedness instructions; physical layout of the facility; sleeping room assignment and introductions; and suicide prevention precautions including alerting staff of their feelings or awareness of others having suicidal thoughts.

A review of three client files revealed that the Orientation process was begun on the date of intake and each client signed their orientation checklist sheet. Each youth was given a list of contraband items, an explanation of: disciplinary actions, the grievance procedure, emergency disaster procedure, rules on contraband, and a layout of the facility were given. They were oriented on room assignments, and suicide prevention precautions including alerting staff of their feelings or awareness of others having suicidal thoughts. Additionally, they received a review of daily activities; they were given and shown postings of the abuse hotline and a tour of the facility.

### 3.03 Youth Room Assignment

Satisfactory                       Limited                       Failed

#### Rating Narrative

The agency has Policy and Procedures related to room and bed assignment that includes an initial classification of the youth for purposes of room or living area assignment with consideration given to potential safety and security concerns. This includes but is not limited to: review of available information about the youth's history, status; initial collateral contacts; initial interactions with and observations of the youth; separation of younger youth from older youth; separation of violent youth from non-violent youth; identification of youth susceptible to victimization; presence of medical, mental or physical disabilities; suicide risk; and sexual aggression and predatory behavior. In addition the agency has a policy and procedure specifically addressing criminal street gangs.

The dormitories are broken down into two separate modules. Module A is for the younger, more vulnerable client while Module B is for the better adjusted youth. There is an island containing lockers, separating the two sides in the dorm and the staff supervising the unit is stationed on the Module A side for maximum supervision whenever youth are in their sleeping quarters. During the Orientation Process, the youth are informed

of their bed assignments. Several factors are considered before placing a youth in a room.

A review of three youth files showed the youth's history, age, gender, disabilities, physical size, gang affiliation, suicide risk, and other risk factors stated above are all considered when assigning a youth to a room.

### 3.04 Log Books

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has Policy Procedures related to the keeping of a bound log book. The policy requires the following:

- Log book entries that could impact the security and safety of the youth and/or program are highlighted in the log book
- All entries are brief and legibly written in ink and include the date and time of the incident, event or activity, names of youth and staff involved, a brief statement providing pertinent information, and the name and signature of the person making the entry
- All recording errors are struck through with a single line and the staff person must sign the correction and the use of whiteout is prohibited
- The program director or designee reviews the facility logbook every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow up are required and signs/dates the entry
- The oncoming supervisor reviews the logbook of the previous two shifts to become aware of any unusual occurrences, problems, etc. and makes an entry signed and dated into the logbook indicating the dates reviewed to document the review
- Direct care staff in the unit reviews the logbook for the previous two shifts and make an entry in the logbook and sign/date that they have reviewed it.

The Agency maintains a daily log book, bound with sequential pages, that includes entries from each shift. They have a color coded system for log entries which include Red, Green, and Blue/Black. All Red items are considered critical to the continued safety of the shelter or the youth in the shelter. It includes information on incidents, medications, medical appointments, grounds and facility checks, and alerts to Staff/Administrator for calls to CCC. All Green information pertains to Shift changes and current status/condition of shelter. It is also used to show Supervisor's review of the log. Blue/Black items are for head counts, visitors and general log entries. A review of the log book showed where recording errors were struck through with a single line. The entries were legible and captured the overall shelter operation. The quality improvement manager reviews the facility logbook weekly and makes a note in the logbook indicating the date reviewed and if any correction, recommendations and follow up are required and signs/dates the entry.

The staff do document shift change and staff turnover but do not each specifically document that they have reviewed the log book for at least the previous two shifts as required by the standard and stated in the agencies policies and procedure.

#### Rating Narrative

The agency has Policy and Procedures covering all elements of behavior management system and a detailed written description. The Behavioral Management System (BMS) being used by Miami Bridge-Homestead is a positive reinforcement model that accentuates and promotes acceptable behaviors by the youth.

The system consists of four levels. Orientation, Level I, Level II, and Level III. Point logs are kept and a client has to accumulate 100 points to advance to each level (i.e. it takes 100 points to advance from orientation to level I, 200 points from I to II and 300 points to advance to level III). An advancement in levels means the client receives more incentives. The shelter maintains a cabinet filled with items for the clients to purchase with their earned points. It's equipped with clothing items, special food items, and an assortment of items that the youth can use. In addition special outings are used as an added reward/incentive within the behavior management system.

Staff are oriented and trained in the theory and use of the BMS and evaluated in its use. Supervisors are trained in its use and to monitor staff's use of the BMS.

Grievance reports are readily available to youth and a process is in place for supervisors to review all grievances with youth within 48 hours and with staff if applicable so that a resolution can be reached all three youth interviewed were aware of the grievance process and two youth rated it fair and the other youth rated it good. CIT/TEAM is the training curriculum that is currently used for physical intervention if necessary as a last resort and was last conducted in November 2013. All three youth interviewed stated that they felt safe at the shelter

### 3.06 Staffing and Youth Supervision

Satisfactory  Limited  Failed

#### Rating Narrative

The agency has a policy for staffing and youth supervision as well as Youth and Facility searches to ensure adequate staffing is provided that optimizes the safety and security of all youth and staff. The program maintains minimum staffing ratios as required by Florida Administrative Code and contract.

The agency has a weekly staff schedule that is developed by the Program Manager and is posted in the staff office in the shelter. The schedule includes youth care staff work hours/days over three shifts. The three shifts run from 6:30 AM to 3:00 PM, 2:30 PM to 11 PM and 10:30 PM to 7 AM. This provides for a 30 minute overlap between shifts to facilitate the transfer of information between staff working on different shifts. The shelter is licensed for 20 beds and the staff schedules reviewed for the review period reflect a minimum staffing ratio of 1 staff to 6 youth during the afternoon shift and 1 staff to 12 youth during sleep period. The program always had at least two staff working during the evening shift and always had a male and female on shift. The program has an on-call roster that includes the names and telephone numbers of staff who may be accessed when additional coverage. A review of the program logbook shows that 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 when youth are in their sleeping rooms. The program has a video surveillance system with 27 total cameras (11 interior and 16 exterior) and the current system backs up the video surveillance footage for 15 days. Review of camera video confirmed staff was conducting 15 minute while youth were sleeping in their rooms.

### 3.07 Special Populations

Satisfactory  Limited  Failed

#### Rating Narrative

Miami Bridge Homestead is a designated Staff Secure and Domestic Violence Respite (DV Respite) provider and has a policy 3.09 for Staff Secure Shelter and Staff Secure Beds place. A separate Intake Guideline for referrals of DV Respite youth is maintained by the program that was last revised December 2013. The agency has no record of a Staff Secure youth intake that occurred during the onsite visit or since the last QI review. Staff was interviewed and confirmed not having a recent staff secure youth in the program. However, the program has a policy and procedures that meet the requirement for accommodation, supervision, and services to staff secure youth.

During the onsite visit, the program did not have any active DV Respite youth on its census. Consequently, three (3) DV Respite files that were closed during the past six months were reviewed to ascertain practice. The three files reviewed demonstrate that the youth met the criteria for DV Respite placement. Prior approval was received via email from the Florida Network for Domestic Violence Respite placement for all three files. As evidenced by the JAC Screening, all three youth had pending Domestic Violence (DV) charge and were screened by the JAC /Detention or screening unit, but did not meet criteria for secure detention. None of the youth's length of stay in DV Respite placement exceeded the 14 days allowed. Two of the three files were transitioned to CINS/FINS; however, there was no documentation in the files showing this transition. The transition dates were updated in the youth's Netmis record.

The Case Plans of two applicable youth reflected goals for aggression management, coping skills, and/or other interventions designed to reduce propensity for violence in the home. Documentation of needs and appropriateness of services was missing in one of the two Service Plans and the frequency of services was also not indicated for 3 of the goals listed. Services provided to these youth were similar to services that are provided to youth in the CINS/FINS program.

Two of the three DV files reviewed were transitioned to CINS/FINS; however, there was no documentation in the files showing this transition.

Documentation of Needs and appropriateness of Services was missing on the Service Plan for one of the two DV Service Plans reviewed and the frequency of services was also not indicated for 3 of the goals listed.

## Standard 4: Mental Health/Health Services

### Overview

#### Rating Narrative

MB Homestead has specific procedures related to the admission, interviewing and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. Upon admission, program staff will interview youth. An initial assessment occurs to determine the most appropriate Room Module assignment, Module A or Module B, given the youth's needs and issues, the current population at the facility, physical space available and staff's assessment of the youth's ability to function effectively within program rules and expectations.

Staff conducting the initial interview and assessment considers the youth's physical characteristics, maturity level, history including gang or criminal involvement, potential for aggression, and apparent emotional or mental health issues. Based on this information, the youth is assigned a bed which can change after further assessment. Room assignment is documented on the CINS/FINS Intake Assessment page 2.

Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The Chief Clinical Officer and Program Manager are notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented on the alert board, youth alert forms, and in the youth files using a color coding system.

Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission. Medications are stored in a double locked medication cabinet and topical and/or injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication which ensures that an approved staff is scheduled on each shift. Medication records are maintained for each youth and stored in a MDR Binder.

The agency is very unique in that they are one of only a few that has a full time Licensed Practical Nurse to oversee the intake health screening, physical health assessment and medical follow-up process. This position plays a critical role in supporting shelter operations during the initial intake and screening process and in making appointments and transporting youth for any follow up medical services. The position is staffed by a certified LPN who was interviewed by the review team during this CQI site visit to verify her assigned duties and responsibilities.

### 4.01 Healthcare Admission Screening

Satisfactory                       Limited                       Failed

#### Rating Narrative

The program had policy and procedures in place for healthcare admission screening. The program procedures include a thorough referral process and a mechanism for the necessary medical care follow-up for youth admitted with chronic conditions.

A review of four youth case files found that in all the cases the provider completed a preliminary healthcare screening that included all the elements required. The review of the files confirmed that in all the applicable cases the parents/guardians were involved in the coordination and scheduled of follow-up medical appointments, and all the medical referrals were documented by the provider staff on the daily log.

### 4.02 Suicide Prevention

Satisfactory                       Limited                       Failed

#### Rating Narrative

The provider has current policy in place that details the suicide prevention and response procedures. The providers procedures complies with the Florida Network's CINS/FINS manual requirements, and includes suicide risk screening and referral for assessment, assessment of suicide risk, and levels of supervision.

A review of four youth cases confirmed that each youth in the facility received a suicide risk screening during the initial intake process. In all the cases reviewed, the result of the screenings were reviewed, signed and dated by the supervisor, and documented in each youth's file. Interviews with one clinical counselor and the licensed practical nurse (LPN), and documentation reviewed revealed that has not been any youth Baker Act since the last review. A review of three staff surveyed indicated that the provider kept suicide response kits in the staff station desk, the supervisor's office and one vehicle.

The staff surveyed also revealed that if a youth expresses suicidal thoughts direct care staff notified a mental health authority, place youth on constant sight and sound supervision, documented the supervision, and search the youth, and the youth's room for hazards. Training documentation reviewed indicated that all the program staff received training in suicide prevention.

#### 4.03 Medications

Satisfactory                       Limited                       Failed

##### Rating Narrative

The program has current policy and procedures for the storage, access, inventory, administration, documentation and disposal of medication.

Observation found that all the medication in the program was stored in the intake office area that is inaccessible to youth. Only the program director, the nurse and the shift leader have keys for the intake office. Oral medication was not stored with injectable or topical medication. The program had a refrigerator located in the nurse station that was empty, clean and maintained at required temperature by the nurse, for use as needed. There were no narcotics in the program at the review time. Controlled medications were observed stored behind two locks. The program had a perpetual inventory with running balances for controlled substances, and shift-to-shift inventory counts.

Each's youth medication was stored in a separate Ziploc bag. The program had a written list of staff authorized to distribute medication. Only staff authorized in writing can distribute medication. The program had over the counter medications that are accessed regularly and inventoried weekly. There were no syringes and sharps in the program at the time of the review.

The program maintained a medication distribution log that documented the distribution of medication by non-licensed staff. The nurse utilized medication distribution logs to document the distribution of medication by her. The Observation of distribution of medication by the nurse to a youth confirmed that she followed all the required procedures and documentation steps. The provider maintained a monthly disposal of biomedical and medication waste log.

#### 4.04 Medical/Mental Health Alert Process

Satisfactory                       Limited                       Failed

##### Rating Narrative

The program has policy and procedures related to the medical and mental health process.

A review of the program documentation found that the program had an alert system that ensures information about the medical, nutritional, substance abuse and mental health of each applicable youth is documented and communicated to staff. Observation found that the program maintained a current alert color code board in the intake office, and a special nutritional instructions food allergy alert in the kitchen.

A review of four youth applicable residential files found that each file contained a color code behavior/medical alert that also includes the youth's medical grade classification system. Staff surveyed indicated that they are informed of the youth's medical/mental health alerts through the alert form, the shift meetings, the log book, and the youth's files.

#### 4.05 Episodic/Emergency Care

Satisfactory                       Limited                       Failed

##### Rating Narrative

The provider has a posted Emergency Preparedness Manual that includes on-site first aid and emergency care, suicide threat attempt or completion, and medical emergencies. In addition, the provider had written policy and procedures related to episodic/emergency care that include all the mandatory components.

Training documentation reviewed found that the program staff received training in cardiopulmonary resuscitation (CPR), Cardio cerebral Resuscitation (CCR), first aid, and knife-for-life. A review of the provider's Emergency Drill Log confirmed that the staff completed and documented monthly medical and/or natural disasters drills.

A review of four applicable youth files found that all the youth required off-site emergency medical or dental care and in each case the parents/guardians were timely notified and the medical attention provided was documented utilizing the provider's Client Transported Offsite Due to Emergency Medical Attention's form. An interview with the licensed practical nurse (LPN) confirmed that in three of the four

applicable cases she transported youth for emergency care, and in one case the youth's mother provided the transportation.