Florida Network for Youth and Family Services
Compliance Monitoring Report for

MIAMI BRIDGE YOUTH AND FAMILY SERVICES, INC.
2810 NW South River Drive
Miami, FL 33125

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for Miami Bridge Youth and Family Services, Inc. (Miami Bridge) for the FY 2019-2020 at its program offices located at 2810 NW South River Drive, Miami (Central) and the Homestead location at 326 NW 3rd Ave., Homestead, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. Miami Bridge is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance, and are funded with General Revenue Funds effective for July 2019 through June 30, 2020.

The reviews were conducted by Marcia Tavares, Consultant for Forefront LLC and Peer Reviewer(s). Agency representatives from Miami Bridge present for the entrance interviews were: Dorcas Wilcox, Chief Executive Director; Alicia Sherman, Director of Finance; Mary Behr, Chief Programming Officer; David Sharfman, Chief Facilities and Construction Officer (Central entrance only); Tracy Scott, RN/Homestead Shelter Supervisor; Lashonda Chavis, Director of Admissions; Richard Rabathaly, CQI Coordinator; and Martha Martinez, HR Generalist. Additional staff listed on the sign in sheets including behavioral services directors, program supervisors, clinical staff, and health care specialists were present at their program specific entrance conferences. The last onsite QI visits were conducted November 12-13, 2018 at the Central Miami location and November 28-29, 2018 at the Homestead, Miami location.

In general, the Reviewer found that Miami Bridge is in compliance with specific contract requirements. **Miami Bridge received an overall compliance rating of 92% for achieving full compliance with twelve (12) of the thirteen (13) applicable indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit; however, one recommendation was made for an indicator rated as conditionally acceptable regarding untimely completion of reconciliation reports.

The following report represents the results of the in-depth evaluation of the provider's General Administrative performance, with all findings clearly documented. Copies of all completed tools utilized during the visit to determine these ratings will be maintained on file with the Reviewer. If any information or clarification is required, please contact Keith Carr by E-mail: keithcarr@forefrontllc.com

2019-2020 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 10-23-2019-2020

Agency Name: Miami Bridge Youth and Family Services Inc.	Monitor Name: Marcia Tavares
Contract Type : CINS/FINS	Region/Office: 2810 NW South River Dr., Miami, FL 33125
Service Description: Comprehensive Onsite Compliance Monitoring	Site Visit Date(s): October 23-24, 2019 (Central) and November 6-7, 2019 (Homestead)

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	The provider currently has two certified DJJ-QI Peer Reviewers: Lashonda Chavez and Richard Rabathaly. Mr. Rabathaly has already participated in 2 QI Reviews for the FY 2019-2020 and Ms. Chavez is also scheduled to participate prior to the end of the FY.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: A list of ten additional funding sources for FY 2019-2020 was provided. The list included funders such as the Batchelor Foundation, Children's Trust, United Way, MDC CDBG, Peacock Foundation, Miami Foundation- Moon/Sash & LGBTQ, Our Funds, and Department of Health and Human Services. The provider also maintains an extensive list of over 48 MOUs with Non/ For Profit agencies who provide medical, mental	

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						health, social, recreational, residential, and other ancillary services.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☒	☐	☐	Documentation: General Liability through Philadelphia Indemnity Insurance Company, for limits of coverage $1,000,000 each $3,000,000 aggregate, effective 12/27/18-12/27/2019 Workers Compensation insurance is provided through NY Marine General Insurance Co. with limits of $500,000 each/ $500,000 aggregate, effective 12/27/18-12/27/2019 Automobile insurance through Philadelphia Indemnity Insurance Company for combined single limit of $1,000,000 for agency vehicles; medical payments coverage is $5000 but liability limits coverage up to 1,000,000 will be applied if medical payments exceed the initial $5,000. Policy effective for 12/27/18-12/27/2019 The provider also has an Umbrella	

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						policy through Philadelphia Indemnity Insurance Company, for limits of coverage $1,000,000 each and aggregate, effective 12/27/18-12/27/2019 and Management Liability insurance through Arch Insurance Company with limits of coverage $1,000,000 aggregate, effective 1/1/2019-1/1/2020. Florida Network is listed as certificate holder on the Certificate of Liability Insurance.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☒	☐	☐	During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by any external funding sources other than the Florida Network as of the date of the visit. As a result of a Management Review conducted by the FN, the provider submitted a CAP and most recent follow-up responses in October 2019.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with	☐	☐	☒	☐	☐	Documentation: A copy of the agency's Fiscal Policies and Procedures was received onsite (Section 7 of the agency's SOPs). The	

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GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**						procedures appear to follow general GAAP guidelines and include procedures for: Financial Planning and Reporting; Internal Control; General Accounting and Records; Cash and Investment Management; Income and Accounts Receivable; Expenses and Accounts Payable; Property, Plant, and Equipment; Travel and Transportation Expense; and Payroll Processing. The most recent revision date documented 7/01/2018. It is reviewed annually at the Board meetings. Changes are reviewed by the Finance Committee and presented to the Board for approval.	
b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	The Agency utilizes Quick Books Enterprise to manage its finances for the agency and maintains an expansive and detailed General Ledger (GL) in which the CINS/FINS Program (account # 5001) is tracked separately. Department codes are designated for subcomponents of the CINS/FINS program. It appears that the agency is allocating cost per each program separately from other funding	

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						sources. The GL uses a chart of accounts and each entry includes the type of transaction, date, reference number, source name, Memo, debit/credit activity, and balance. The GL for the CINS/FINS Program for the period July 1-October 22, 2019 was reviewed and is on file with the reviewer.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Documentation and Observation. Each shelter has a gas card and a Purchase card for operation purposes. Miami Bridge utilizes Purchase Cards (P Cards) instead of petty cash to provide a more efficient and cost effective method for purchasing and paying for small dollar amount transactions, repetitive purchases, and high volume transactions. A copy of the P&P for use of the purchase cards is on file with the reviewer. P Cards are issued only to Department Chiefs and designated Managers and are issued in the individual's name. A card custody log is maintained by the card holder to establish custody. Additionally, each card holder must	

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						sign a Cardholder Responsibilities Agreement with the agency. Per the P&P, the limit on the P card is $600 for Shelter Directors. Pcard purchases statements are downloaded in Excel monthly and itemized based on the transaction by the staff accountant. A receipt log is attached to each transaction along with the related receipt. A list of clients participating and their signatures is attached to client related activities. Card for the shelter is kept in a locked box. P card purchases are documented on a Purchasing Card Transaction Report form which is submitted to the fiscal office, along with the supporting purchase documentation, for monthly reconciliation. Each card is assigned a single ledger account code.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation.	☐	☒	☐	☐	☐	Bank Statements and Reconciliation Reports for the period March1-October, 31 2019 for the provider's Operating Bank account with TD Bank	**Recommendation: 1)** Four of the eight bank reconciliations for the months of May, August, September, and October were prepared on 7/29/19,

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(Disbursements/invoices are approved & monitored by management). **ON SITE**						were reviewed. Based on a review of these documents, it appears that 2 of the 6 bank reconciliation for May and August's bank statements were prepared greater than 6 weeks of receipt of the bank statement, 7/29/19 and 10/22/19, respectively. Source documents are documented, tracked, and reconciled by fiscal staff. Bank reconciliations are approved by both the CEO and Director of Finance. Invoices are submitted on a monthly basis with supporting documentation. Payments are approved by the agency's Finance Department. Vendor files are maintained by the Book Keeper.	10/22/19, 11/14/19, and 11/15/19 respectively, greater than 6 weeks of receipt of the bank statements. The provider must ensure that bank reconciliations are processed timely within 6 weeks of receipt of bank statements and reconciliations clearly document approval signatures and dates of approval.
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☒	☐	☐	The provider maintains a record of program inventory via the Asset Account. No new equipment was purchased since the last onsite visit. Equipment is viewed as fixed asset (item that has a useful life that exceeds 1 year) and cost exceeds $1000.	
f. Agency submits payroll taxes and deposits (and	☐	☐	☒	☐	☐	Federal 941 payments are being	

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	Explain Rating						
retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**						prepared, processed, and submitted timely at a minimum twice per month through the authorized contracted reporting agent Dominion Payroll. The payroll payments are processed electronically by Dominion. Copies of the provider's 941s for the 1st, 2nd, and 3rd quarters of 2019 along with supporting documentation was reviewed. No balances due were reported.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Agency provided Budget vs. Actual report for the period July 2019 through October 18, 2019 showing a net income balance. A review of these documents was conducted and it appears they are in order. These reports are reviewed with the Finance Committee monthly and variances are explained.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to	☐	☐	☒	☐	☐	As of the date of the onsite visit November 6, 2019, the most recent Financial Audit was completed December 19, 2019 by Verdeja, De Armas, and Trujillo CPA, for June 30, 2019 and 2018. The audit did not note	

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the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**						any findings and/or questioned costs. A Management Letter was not issued for the year ended June 30, 2019 and no matter of non-compliance or findings of deficiencies in internal control was reported by the audit. Consequently, a corrective action was not required.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	The agency provided confidentiality policy documents regarding the protection of agency and client information. Fiscal and personnel data is maintained on the agency network system which is backed up daily. The COO is responsible for the backup, changing, and custody of the portable drive. Data is backed up on ICLOUD as well as a portable drive which is taken off premises. Youth records are maintained in Lauris an online electronic system. User's access is password protected and activity is monitored and logged.	

CONCLUSION

Miami Bridge has met the requirements for the CINS/FINS contract as a result of full compliance with 12 of the 13 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Consequently, t**he overall compliance rate for this contract monitoring visit is 92%.** There are no corrective actions cited but one (1) recommendation is made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

SUMMARY OF RECOMMENDATION(S)

Recommendation (1)
Four of the eight bank reconciliations for the months of May, August, September, and October were prepared on 7/29/19, 10/22/19, 11/14/19, and 11/15/19 respectively, greater than 6 weeks of receipt of the bank statements. The provider must ensure that bank reconciliations are processed timely within 6 weeks of receipt of bank statements and reconciliations clearly document approval signatures and dates of approval.

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

Recommendations (1) are suggestions regarding general program and operations issues observed during the review. This recommendation has been cited as needing attention but does not necessarily require a written response.

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Miami Bridge - Central, Miami, Florida
Residential Program

October 23-24, 2019

Compliance Monitoring Services Provided by

Quality Improvement Review

Miami Bridge Central – October 23-24, 2019
Lead Reviewer: Marcia Tavares

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 71.4%
Percent of indicators rated Limited: 28.6%
Percent of indicators rated Failed: 0.00%

Standard 2: Intervention and Case Management

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

Percent of indicators rated Satisfactory: 88.9%
Percent of indicators rated Limited: 11.1%
Percent of indicators rated Failed: 0.00%

Standard 3: Shelter Care & Special Populations

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

Percent of indicators rated Satisfactory: 85.7%
Percent of indicators rated Limited: 14.3%
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: 85.71%
Percent of indicators rated Limited: 14.29%
Percent of indicators rated Failed: 0.00%

Rating Definitions

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

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

Reviewer

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services

Rondarrell George – Regional QI Monitor, Department of Juvenile Justice

Raymond Ballinger – Executive Director-Lutheran Services Florida Southeast

Paivi Johnson – Residential Counselor, Florida Keys Children's Shelter

Joan Jordon – Clinical Program Manager, Children's Home Society West Palm Beach

Quality Improvement Review

Miami Bridge Central – October 23-24, 2019
Lead Reviewer: Marcia Tavares

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, (3) Shelter Care, and (4) Mental Health/Health Services which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2019).

Persons Interviewed

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

Documents Reviewed

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

Surveys

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

Observations During Review

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

Comments

Additional Comments regarding observations, other important findings of interest, etc.

Strengths and Innovative Approaches

Rating Narrative

Miami Bridge Youth and Family Services, Inc. contracts with the Florida Network to operate the Child in Need of Services and Family in Need of Services (CINS/FINS) program in two locations, Miami Bridge Central Shelter (MB Central) located in North Miami and a south shelter located in Homestead, Florida. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The agency also provides services to special populations who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Family/Youth Respite Aftercare Services (FYRAC). MB is designated by the National Safe Place Program as a Safe Place provider who is responsible for building a network of safe place sites in the community to provide help and access to run away and homeless youth. Miami Bridge is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through August 31, 2021. 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 employs professionally licensed staff for both mental health and medical services. Its licensed Mental Health professionals provide oversight of its counseling services at both locations. In addition, there is a Registered Nurse who works at both facilities to oversee the referral for health care services and medication management of youth in care.

Since the last Quality Improvement visit in November 2018 Miami Bridge has implemented new programs and has continued to enhance services to youth and families as follows:

Facilities:
Sixty-three volunteers from all over the country donated time and $125,000 during the Corporate Day of Service event to renovate the shelter dining room with new furnishings, décor, lighting; add 8ft trees and privacy fence around the perimeter of the grounds; renovate the conference room; and installed LED lighting to the kitchen, laundry room and hallways. Additional CBDG funds contributed to the renovations of the exterior deck, addition of picnic tables and commercial fans on the back deck of the building, and seating around the volleyball court.

Programming

- Miami Bridge successfully completed the first year of its Nurturing Parenting Program (funded by the Children's Trust). The grant serves 60 families through 12-week cohorts who participate 3 hours/week. Last year a total of 72 families were served
- MB received $50k grant to hire full time specialist to work with the LGBTQ youth and families who will provide groups in home and offsite to educate families and prevent out of home placements
- Youth and families had their second annual overnight trip during the summer to Orlando, FL, by way of Batchelor Foundation Grant and donations in kind
- Batchelor Foundation and Miami Foundation provided funds for youth to have a summer program
- New science, technology, engineering, and math (STEM) equipment consisting of 2 virtual reality machines to support the education of youth

General
The agency continues to reach out to the community by hosting multiple events throughout the year and has earned success with the following events held during the current FY:

- Annual Gala - April 2019
- Physicians Fishing Tournament Florida Keys – July 2019
- Annual Luncheon - October 2019
- Central Shelter makeover with Motorola Corp. - October 2019

Standard 1: Management Accountability

Overview

Narrative

MB Central, located at 2810 NW South River Drive, Miami, Florida, is under the leadership of a Board of Directors, Chief Executive Director, Director of Finance, Chief Programing Officer, Chief Operations Officer, Chief Administrative/Compliance Officer, Director of Admissions, Director of Shelter Services, Director of Community Based Services, and 2 Shelter Supervisors, one of which is also the Registered Nurse. The Chief Executive Director oversees the Miami Bridge agency and the services provided in Central Miami and Homestead, Florida. The Director of Shelter Services, intended for a licensed professional who oversees the clinical component for both shelters, was vacant during the visit. Other vacant positions included a book keeper and 3 YCS.

MB Central office handles all fiscal, administrative, and personnel functions for both locations. This site is the location of the offices for all the Administrators; however, the CEO and other agency-wide administrative staff split their time at both locations and visit the Homestead program regularly. The HR specialist processes all state and local background screenings and human resource functions.

The program experienced significant turnover in several positions since the last onsite review and reported a total of 18 staff members resigned since last audit. Some of the key positions involved in the turnover include the following:

- HR Generalist resigned January 2019
- CFO/Deputy CEO resigned in May 2019
- Finance Manager resigned in June 2019
- Chief Program Officer resigned in June 2019 but decided to stay on until year end
- Recreational Coordinator/Administrator resigned July 2019, but returned as weekend YCC
- LCSW - Clinical Director of Residential Services, both Miami and Homestead resigned August 2019
- Chief Administration and Compliance resigned in September 2019

Miami Bridge has a Performance Quality Improvement (PQI) plan that describes the structure and protocols involved in the monitoring, evaluation, and improvement of its processes and outcomes. The agency has a CQI Steering Committee that meets regularly. Sub-committee membership includes staff of various levels from both the Central and Homestead location. To support PQI processes, the organization will analyze data in relation to the following:

- Consumers (Client Outcomes, Demographics),

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- Program/services (Outcomes, Medication and Behavior Management, Service Delivery),
- Performance (Client and Employee Satisfaction),
- Risk management (Incident Reports, walkthroughs),
- Financial management, integrity viability

The risk prevention review is conducted via periodic management meetings to assess areas that pertain to Miami Bridge's administration. The Risk Prevention Review consists of representatives from human resources, performance quality improvement and Shelter Directors who will review processes and specific documents to identify patterns/trends in need of attention. Recommendations and suggestions will be discussed and documented in the PQI report and submitted quarterly.

The program has not reported any major incidents since the last QI visit but indicated a management review was conducted by the Florida Network earlier in the year. During the QI review while conducting formal and impromptu interviews, the Lead Reviewer was alerted to a few incidents and/or issues that were discussed with the CEO. A summary of the issues are documented below:

- A confrontation between a male and female staff resulting in allegation by female staff of feeling threatened and/or intimidated by male staff occurred 10/16/19 prior to the QI visit but was not initially reported to the review team as an internal incident. Upon discovery, the reviewer was provided a copy of the incident report form documenting staff concerns and communication to management about responding to the incident. However, as of the QI visit, no formal actions were initiated to investigate and address the incident/allegations or take management actions with involved staff to ensure a safe environment.
- General allegation of lack of response by management to address employee concerns, salary increases/raises/bonuses, hiring practices (e.g. hiring low rated applicants), and lack of transparency.
- The CEO reported a significant turnover of 18 positions in the current year; there were 3 vacant YCS positions during the visit and current direct care resignations underway
- Five random staff surveys conducted during the review indicated concerns with the working conditions of the shelter; four of the five stated conditions fair (3) and poor (1). Comments included not being treated fairly, feeling disrespected, and unfair employee recognition process (same employee/s all the time)
- There was a desire verbalized by staff to have access to speak directly with the FN, not only during the audit

- It was reported that during the FN Management review onsite, some key staff were excused from duty, hence were not accessible to the review team

Two of the indicators in standard 1 were rated limited and three were rated satisfactory with exceptions. The two indicators rated as limited are:

- 1.01, Background Screening: one 5-yr rescreening that was not conducted during the required timeframe; however, this is a repetitive finding for two consecutive QI reviews. In addition, four applicable new hires completed the Berke Assessment and three of the four were hired despite a "low" rating on the assessment. In addition, the assessment was completed after the hire date for 2 of the employees.
- 1.04, Training: three first year staff were not compliant in completing all mandatory trainings required during first 120 days of hire. Additionally, in-service staff were not current on completing mandatory annual/biannual training.

Indicators rated as satisfactory with exceptions include:

- 1.02, Abuse Free Environment: one (1) grievance (4/27/19) was not addressed within the 72-hour window; administrator's review was missing for one of the grievances; and intervention for two grievances were not signed or dated by the youth and staff member
- 1.03, Incident Reporting: three of the 13 CCC reportable incidents were reported outside the 2-hour notification timeframe
- 1.06, Transportation: five (5) designated drivers were not listed as insured on the agency's automobile insurance company. Also, the electronic transportation log does not record the mileage of each youth transport and there were 2 incidents which do not include the names or initials of the drivers. Two incidents of single youth transport did not document supervisor's awareness or with prior approval.

The remaining indicators were rated satisfactory with no deficiencies.

Standard 2: Intervention and Case Management

Overview
Rating Narrative

Miami Bridge Youth and Family Services is contracted to provide both shelter and nonresidential 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 for youth who meet the criteria for CINS/FINS, Staff Secure, DV and Probation Respite, DMST, and FYRAC. The program has an Admission's Director 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 and family counseling, 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.

The clinical component of the program is under the supervision of a licensed Clinical Director. For the Central location, a total of four Non-residential Counselors and two Residential Counselors are responsible for providing counseling and case management services and linking youth and families to various community services.

The agency completed a full year of utilizing Lauris, an online automated case management and counseling system, for the residential and non-residential CINS/FINS program. This system was launched in July 2016 to optimize the organization's service delivery and information management processes as well as afford the ability to automate workflow and manage all aspects of services. There has been significant progress in made to customize the system as well as integrate closed files subsequent to the launch.

All indicators in standard two were rated satisfactory with the exception of the following indicator rated as limited:

- 2.03, Case/Service Plan: the service plan was not developed within seven (7) working days of the needs assessment in five of ten files reviewed. Key components of the service plan were missing (frequency, target date, signatures) in a few of the records. One (1) non-residential file did not have an evidence of a service plan being developed. Finally, four of the plans did not have documentation of 30 day follow-ups

The following indicators were rated as satisfactory with exceptions:

- 2.02, Needs Assessment: the needs assessment was not completed within 72 hours of admission in two (2) residential files, and one (1) chart was missing the supervisor's signature on the assessment
- 2.05, Counseling Services: the program did not meet the requirements of having groups at least 5 times a week and many of the notes did not include topic, date, or the time, hence had to be eliminated from the count.
- 2.08, SOGIE: the program did not have documentation to support new staff being made aware/having knowledge of Florida Network policy #5.08. None of the 5 new staff training files reviewed confirmed a practice is currently in place.
- 2.09, Special Populations: two of the files indicated youth received individual/family and group counseling during care. Also, one of the 3 files did not have a case plan developed.

All other indicators in standard two were rated satisfactory with no deficiencies.

Standard 3: Shelter Care

Overview
Rating Narrative

Miami Bridge Central 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 building includes a large day room, girls' and boys' sleeping rooms, dining room, kitchen, laundry, staff offices and a conference room. During the Quality Improvement review, the shelter was found to be in good condition, 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 large bathrooms, one on each dorm wing. The bathrooms consist of three sinks, six showers and three toilets. The bathroom floors are tiled and the plumbing appeared functional. The sleeping rooms house fourteen (14) youth each. The sleeping room is equipped with bunk beds and each youth has an individual bed, bed coverings and pillows. The windows are frosted to provide privacy for youth. In addition, the youth have access to a computer lab with 6 computers, recreational games, a volley ball court and basketball.

Staff members in the Residential Program include: a Shelter Supervisor, 2 Counselors, 4 Shift Leaders, 7 Youth Activity Workers, a PT Registered Nurse, a Health Care specialist, a Recreation Specialist, and a Food Specialist/Cook. The provider also employs a Maintenance person who is responsible for facility repairs and maintenance for both the Central and South Miami program facilities. The Direct Care workers are responsible for completing all applicable admission paperwork, conducting youth orientation to the shelter, and providing necessary supervision. During the current review period, the agency utilized the manual logbook as well as the electronic logbook

Miami Bridge utilizes a Behavior Management System (BMS) that is based on a system of rewards, privileges, and consequences. The system encourages positive behavior and discourages negative behavior.

All indicators in standard three were rated satisfactory with the exception of 3.06, Staffing (limited) and 3.01, Shelter Environment (satisfactory with exceptions). Indicator 3.06 was cited as limited as a result of staff failing to comply with the required 15-minute bed check increments on three randomly selected overnight shifts. Additionally, consistent deficiencies in the logbooks was observed with staff not writing the time and the date per entry and some dated and timed entries appeared to be pre-populated. Some errors were scribbled out with initials and no date; others had only a line through

it without “void” written. All other indicators in standard two were rated satisfactory with no deficiencies.

Indicator 3.01 was rated satisfactory with exception due to missing fire drills on the second shift in June 2019 and on the second and third shift in August 2019. Also, two of the fire drills exceeded the recommended evacuation time of 2 minutes.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The residential counseling services in the shelter are overseen by a licensed clinical director; however, this position was vacant during the visit and was temporarily being conducted by the CEO who is a LCSW. Trained direct care staff completes screening and CINS/FINS Intake assessment. All case management and/or counseling staff are trained on the suicide risk screening process and utilize the CINS Intake form to initially screen for potential risks prior to placing all youth on sight and sound supervision status.

MB Central 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. 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. An initial assessment occurs to determine the most appropriate room and 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. 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 Clinical Director and Residential Coordinator 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. The agency is storing all prescribed medications in the Med-Station 4000 cabinet and has several staff members as regular users and more than 2 Super Users of the Pyxis Med-Station 4000. The provider has a RN and Health Care Specialist whose main responsibilities are the provision of medical care and medication management in the facility including: oversight of the general practice of distributing medication to residents in the shelter; oversight of medication inventory and storage practices; training of all staff authorized to distribute medication; and completion of health screenings and medical follow ups on an as needed basis. Topical and injectable medications are stored separately from oral medication in the Pyxis Med Station. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication ensures that an approved staff is scheduled on each shift. Medication records are maintained for each youth and stored in a MDR Binder.

All indicators in standard four were rated satisfactory with no exceptions.

STANDARD 1: MANAGEMENT ACCOUNTABILITY

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard One – Management Accountability							
1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						☐ YES ☒ NO (explain) Policy and procedure 1.01 addresses the background screening of all employees, volunteers, and interns prior to any offer of employment or volunteer service. The policy was approved on 7/01/18 by the CEO and Chief Program Officer.	Upon initial review, no policy and procedure was written for the use of the Berke assessment tool, including pass rate criteria to determine suitability for employment. A revision to policy 1.01 was completed and submitted to the reviewer during the review to include the Berke assessment tool and pass rate criteria.
RATING	☐	☒	☐	☐	☐	A total of nine (9) applicable personnel files were reviewed for six (6) new staff, one (1) consultant, and two (2) staff eligible for 5-year re-screening. At the time of the QI visit, the program did not have any volunteers who met the criteria for background screening. All six new hire files maintained evidence of eligible screening results obtained prior to hire. E-verify for the six new employees were reviewed, confirming the employees' work eligibility. Two staff were eligible for their 5-year re-screenings during the review period; the 5-year re-screening was conducted on time prior to one of the two staffs five-year anniversary date. The most recent submission of the Annual Affidavits of Compliance with Level 2 Screening Standards was sent via email to DJJ BSU on 1/14/2019 prior to the January 31st deadline.	**Exception-Limited rating** Four applicable new hires completed the Berke Assessment; however, the overall rating was determined to be "low" for 3 of the 4 employees who were hired. In addition, the assessment was completed after the hire date for 2 of the employees. Both occurrences mitigate the purpose and intent for which a pre-employment assessment is to be utilized. The official start date for a recently contracted consultant was 5/18/2019 per a letter of agreement; however, the background screening eligibility was effective 8/14/2019 after the consultant's

Miami Bridge Central – October 23-24, 2019
Lead Reviewer: Marcia Tavares

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						The reviewer uses the Berke pre-employment assessment tool. Four applicable new hires completed the Berke Assessment; however, the overall rating was determined to be "low" for 3 of the 4 employees who were hired. In addition, the assessment was completed after the hire date for 2 of the employees. Both occurrences mitigate the purpose and intent for which a pre-employment assessment is necessary.	start dart. The 5-year re-screening was not conducted on time prior to one of the two eligible staff five-year anniversary date. The employee's 5-year anniversary was 4/15/2019 but the eligibility determination was not effective until 5/7/2019. As a result of the findings of this indicator in addition to not fully addressing the repetitive issue of completing 5-year re-screenings on time as similarly cited during last year's QI review, this indicator is rated a limited compliance.
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						☒ YES ☐ NO (explain) Policy and procedure 1.02-Provision of an Abuse Free Environment and 1.02.01 Grievance Process address the abuse free environment requirement of indicator 1.02. The policies were last revised and signed by the CEO and CPO on 7/01/18.	No exceptions
RATING	☐	☒	☐	☐	☐	The following items were reviewed: youth surveys; employee training folders; employee and youth handbooks; abuse registry log; and client grievance binder. There are postings throughout the facility of the Florida Abuse Hotline. In addition, the provider reported five abuse calls made between April and October 2019; none of the abuse calls were institutional. All five of them contained evidence that the abuse call forms were completed by a staff member and contained the identifying DCF investigator. The program has a locked grievance box in the common area. It is	**Exception** One (1) grievance (4/27/19) was not addressed within the 72-hour window. The administrator's review was also missing. Two (2) grievances were signed (7/17/19; 7/18/19) by the administrator and the level of intervention was completed but not signed or dated by the youth and staff member.

Miami Bridge Central – October 23-24, 2019
Lead Reviewer: Marcia Tavares

Quality Improvement Indicators	Rating: Satisfactory	Rating (Explain): Deficiency Identified	Rating (Explain): No Eligible Items For Review	Rating (Explain): No Practice	Rating (Explain): Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						located away from the general milieu, but easily accessible to the youth. The QI specialist holds the key to the locked box. This assures that direct-care staff do not handle the complaints/grievances. There were 11 grievances made between April and October 2019. Ten (10) were reviewed and signed within 72 hours by management. There were 3 youth surveys reviewed for 1.02, with 12 items specifically targeting the indicator. None of the youth reported needing to contact the abuse hotline or being stopped from calling the abuse hotline; however, 1 youth stated that he/she did not know that the abuse hotline is available for his/her use and where that number is located in the program. All of the youth indicated adults showed respect and feeling safe at Miami Bridge but 1 youth has overheard a staff use a curse word.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						☒ YES ☐ NO (explain) Policy and procedure 1.03 addresses the requirement of incident reporting. The policies were last revised and signed by the CEO and Chief Administrative and Compliance Officer (CACO) on 7/01/18.	No exceptions
RATING	☐	☒	☐	☐	☐	Thirteen (13) CCC reports between April and October 2019 were reviewed. The breakdown of the reports is as follows: • Absconding (6) • Complaints against staff (2) • Program Disruptions (1) • Program Disruption/Complaint Against Staff (1) • Medical Incident/Complaint Against Staff (1) • Youth Behavior (1) • Miscellaneous (1) All 13 of the incidents were documented in the program logs and on the incident reporting forms. All of the reports had follow-up communication	**Exception** Three of the 13 CCC reportable incidents were reported outside the 2-hour notification timeframe.

Quality Improvement Indicators	Rating: Satisfactory	Rating – Explain: Deficiency Identified	Rating – Explain: No Eligible Items For Review	Rating – Explain: No Practice	Rating – Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						and were signed by program administrators. Ten (10) of the incidents were reported within the required 2-hour required notification timeframe.	
1.04: Training Requirements **Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						☒ YES ☐ NO (explain) Policy and procedure #1.04 addresses the requirement of training. The policy was revised on 7/1/18 and signed by CEO and CACO on 7/1/18.	No exceptions
RATING	☐	☒	☐	☐	☐	There were 9 total employee training files reviewed. Five (5) new direct-care staff members were reviewed for trainings completed during the first year and 2 had exceeded the first 120-days of employment. One of the 2 staff had not completed 9 of the 14 trainings that were due by 9/7/2019 and the second staff missed 3 of the 14 trainings that were due by 2/6/2019. The other 3 new staff still have time to complete the required 120 day training but have between 8 and 10 trainings to complete between 11/23/19 and 12/20/19 based on their hire dates. To date 3 of the 5 had exceeded the 80 hours required annually and two are on track. Four (4) in-service training files were reviewed. None of the 4 had completed all of the required trainings due in their training year. Three of the 4 had exceeded the 40 hours of training due annually.	**Exceptions – Limited rating** Provider was not compliant for first year staff completing all mandatory trainings required during first 120 days of hire. One of the 2 eligible staff had not completed 9 of the 14 mandatory trainings that were due by 9/7/2019 and the second staff missed 3 of the 14 trainings that were due by 2/6/2019. Three staff are in process of completing 120 days but still have a significant number of trainings to complete (between 8-10) by as early as 11/23/2019. In-service staff were not current on mandatory annual/biannual training. None of the 4 files reviewed had completed the annual DJJ SkillPro Suicide Prevention training or were current on the required DJJ SkillPro Human Trafficking training. One staff had not completed the biannual fire safety training and another staff was missing the DJJ SkillPro biannual sexual harassment training. One of the 4 in-

Quality Improvement Indicators	Rating: Satisfactory	Rating (Explain): Deficiency Identified	Rating (Explain): No Eligible Items For Review	Rating (Explain): No Practice	Rating (Explain): Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
							service staff has completed only 3 of the 40 hours required by 12/21/19. There was one shelter clinical staff re-hired in August 2019. No documentation of Assessment of Suicide Risk training was in the current training file or carried over from prior employment.
1.05: Analyzing and Reporting Information **The program collects and reviews several sources of information to identify patterns and trends. Program should have sample reports of aggregated data and committee/workgroup minutes analyzing information.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						☒ YES ☐ NO (explain) Policy and procedures 1.05 addresses the requirement of the indicator. The policy was last reviewed on 7/1/18 and was approved on 7/01/18 by the CEO and CACO.	No exceptions
RATING	☒	☐	☐	☐	☐	Peer record review is conducted quarterly to analyze and evaluate clarity, content and continuity of open/closed records and to determine if youth's needs and strengths are being assessed appropriately. The MIS Manager produces a random list of youth from each program to be reviewed. This list will represent no less than 40% of youth each quarter in each of the programs. Case record reviews for Q3 and Q4, for the period October 2018-March 2019, was completed on June 20, 2019. A total of 130 cases were reviewed. Each report documents the committee members involved, methodology, results for each program, findings, and a tabulated summary. Case record reviews include cases from both Miami Bridge locations. Incident/Accident/Grievance Reports: Incident reports from all Miami Bridge programs will be reviewed daily by the Shelter Director and collected and tabulated weekly regarding the total number of incidents, number of incidents reported to Department of Children and Families	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon	Notes
		Explain				Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						(DCF) and DJJ Central Communications Center, number of incidents per program and actions taken and developing patterns/trends. The Risk Prevention Subcommittee meets monthly (except when quarterly meetings are held) to review incidents, accidents, and grievances. The meeting agenda includes a review of: incidents, grievances, medication, health and safety, flammable control, technology, surveys results when they are completed during the period. Trends and issues are discussed at the quarterly meetings. A review of meetings held for the past 6 months was conducted and were found to be held April, July, two in August, and September 2019. Client grievances are submitted according to Miami Bridge policy. The Shelter Directors and others in authority are required to submit all grievance documentation to the CQI Department after grievances are resolved; these are documented and reported on accordingly. The client and employee satisfaction surveys are completed annually and discussed at the quarterly CQI meeting. Client satisfaction data is retrieved from the Netmis and the employee satisfaction surveys are distributed and compiled by the program. The most recent satisfaction surveys completed for the current FY 2018-2019 was completed with 226 youth respondents. No employee surveys have been distributed since the last QI visit. Outcome data is reviewed quarterly. The reports are separated by Emergency Shelter and First Stop for Families (FSFF). The outcome measures translate directly to contract measures from the programs' funders. Demographic data on clients served is also included. Program outcomes for FSFF, Emergency Shelter, and CINS/FINS Contract were discussed at the CQI meetings held and reviewed. Florida Network Report cards are emailed to the management teams and are discussed during the management morning calls held daily and at the quarterly	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						CQI meetings. The provider has a MIS staff who is responsible for data entry and reviews of Netmis data. NetMis data reports are addressed at each CQI workgroup/committee meeting and documented on the agenda and meeting minutes. The last two quarterly CQI Committee meeting agendas and minutes were reviewed for meetings held in June and August 2019. A sign in sheet, agenda, and minutes is maintained for each meeting. Agenda items include: incident reports, risk prevention, training update, clinical subcommittee update, health care and medication management, client satisfaction surveys (if applicable), review of Netmis report analysis, and case record review report. Evidence of strengths, weaknesses, improvements: The risk prevention review is conducted via periodic management meetings to assess areas that pertain to Miami Bridge's administration. The Risk Prevention Review consists of representatives from human resources, performance quality improvement and Shelter Directors who will review processes and specific documents to identify patterns/trends in need of attention. Recommendations and suggestions will be discussed and documented in the PQI report and submitted quarterly. Last meeting addressing audit findings was conducted in August 2019. Netmis data reports are presented at the CQI quarterly meetings. Meeting minutes from the last CQI quarterly meetings specifically reflect discussion on Netmis data. Staff and management meetings held in 2019 for April (training), May, June (luncheon), July, and August during the QI period provided minutes for each meeting that incorporates findings reviewed at the	

Quality Improvement Indicators	Rating					Review Based Upon	Notes
		Explain				Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						quarterly CQI meetings. The QI Coordinator and/or Chief Compliance Officer participate in the staff meetings to share information related to CQI and program monitoring.	
1.06: Client Transportation **Policy is established to avoid situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						☒ YES ☐ NO (explain) **Indicate policy number, authorized signee, date(s) of last review/revision/approval, and exceptions in notes.** Policy and procedure 1.06 addresses the requirement of client transportation. The policy was approved and signed by the Chief CEO and Chief Facilities and Construction Officer on July 1, 2018.	No exceptions
RATING	☐	☒	☐	☐	☐	MBC maintains a list of approved drivers with valid Florida Driver's licenses and who are covered under the agency's insurance policy. Also, all third-party participants must be approved. MBC's approved driver list was compared with what the automobile insurance agency's list, with 5 drivers currently not eligible to drive for MBC. MBC's electronic log between April through October 2019 was reviewed. The log documents the identity of the driver, date and time, number of passengers and purpose of the travel. The log does not document the miles driven. The agency uses a Department of Transportation application and log that maintains mileage, but does not document all of the other information required by the indicator.	**Exception** Five (5) designated drivers were found to not be listed as insured on the agency's automobile insurance company as of today's date, 10/24/29. Note, MBC immediately took these drivers off their eligible-transport list and contacted the automobile insurance carrier to have these 5 added to the policy. MBC also informed staff and administrators via email that these employees were not eligible to transport youth until further notified. Later in the day, MBC received an email from their automobile carrier that all 5 drivers are now on the agency's automobile insurance policy and are eligible to transport youth. The electronic log contains 2 incidents (4/19/19 and 4/27/19) which do not include

Quality Improvement Indicators	Rating					Review Based Upon	Notes
		Explain				Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
							the names or initials of the drivers. The electronic log does not record the mileage of each youth transport. The log also indicates that there are 2 incidents (5/17/19 and 6/12/19) which single youths were transported without documenting supervisor's awareness or with prior approval. There is no one reporting tool that captures all the information specified in the policy and no documentation proving that the transportation event occurred.
1.07: Outreach Services **The agency participates in local DJJ board and council meetings to increase public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services and ensure CINS/FINS services are represented in a coordinated approach.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						☒ YES ☐ NO (explain) **Indicate policy number, authorized signee, date(s) of last review/revision/approval, and exceptions in notes.** Policy and procedure 1.07 addresses all key elements of the indicator for outreach services and interagency agreements. The policy was reviewed and approved on 7/1/18 and was signed by the CEO and CACO.	No exceptions
RATING	☒	☐	☐	☐	☐	Designated staff participates in local DJJ board and council meetings to ensure CINS/FINS services are represented in a coordinated approach. Miami Bridge also maintains written agreements with other community partners that include services provided and a comprehensive referral process. The assigned representatives to these	No exceptions

	Rating						
		Explain					
Quality Improvement Indicators	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						groups will advocate for the effective use of CINS/FINS services and update agency leadership on meeting activities. There is a lead staff member designated to attend local and circuit level meetings convened by the Department of Juvenile Justice as well as staff designated to coordinate and provide outreach services to community audiences, individuals, and groups. Outreach activities are documented in the Netmis database. The provider participated in local DJJ board and council meetings. A review of the binder maintained with the meeting agendas and minutes were provided and showed designated staff member attends. If the meeting was cancelled, the agency keeps necessary documentation as well. The agency provided evidence of attendance two of the six board meeting of the 11th Judicial Circuit Advisory Board Meetings held during the past 6 months; the provider reported four of the meetings were cancelled. Reviewed outreach event for the past six month of the program Outreach Binder verified the program maintain an updated Outreach Plan and printouts by month from Netmis of all the Events that designated staff performed. During the review period, the agency participated in numerous community events to advocate for the effective use of CINS/FINS services and ensure that community partners are aware of Miami Bridge scheduled events. The program participated in a total of 31 outreach events.	

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STANDARD 2: INTERVENTION AND CASE MANAGEMENT

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
Standard Two – Intervention and Case Management							
2.01: Screening and Intake							
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						☒ YES ☐ NO (explain) Policy and procedures 2.01 addresses the screening and intake requirement. The policy was last reviewed, signed, and dated by the CEO and CPO on 7/1/18.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of ten (10) files were reviewed for 5 residential and 5 non-residential youth. All 10 files reviewed demonstrated eligibility screening completed within 7 days of referral. In 9 of 10 files it was evidenced during intake that youth and parent/guardian received available service options, rights and responsibilities, parent brochure, possible actions through involvement with CINS/FINS, and the grievance process. One file did not provide evidence of receipt of rights and responsibilities or parent brochure. It was observed that in one (1) of the non-residential files, the screening was completed on 2.11.19 and the intake was not done until 7.25.2019 and no progress note was documented to explain the gap. Also, one of the non-residential forms ("Introduction to the Bridge) was not signed or dated by any staff.	No exceptions
2.02: Needs Assessment							
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						☒ YES ☐ NO (explain) Policy and procedure 2.02 addresses the requirement for needs assessment. The policy was last revised on 07/01/18 and signed by the CEO and CPO.	No exceptions

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Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
RATING	☐	☒	☐	☐	☐	A total of ten (10) files were reviewed for 5 residential and 5 non-residential youth. In three (3) of the five (5) residential files, the needs assessment was completed within 72 hours of admission and four (4) out of five (5) assessments were signed by the supervisor. All non-residential files met the requirements for this indicator and the needs assessments were completed within 2-3 face to face visit. One (1) out of five (5) residential files and one (1) out of five (5) non-residential files did not include the dates of initiation and completion on the form – this same file was noted to not be completed in its entirety. All 10 Needs Assessments were conducted by a Bachelor's or Master's level staff member. None of the files reviewed were identified with an elevated risk of suicide.	In two (2) of the five (5) residential files, the needs assessment was not completed within 72 hours of admission and one (1) out of five (5) charts was missing the supervisor's signature on the assessment.
2.03 Case/Service Plan							
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						☒ YES ☐ NO (explain) Policy and procedures 2.03 addresses the requirement for case/service plan. The policy was last revised on 07/01/18 and signed and dated by the CEO and CPO.	No exceptions
RATING	☐	☒	☐	☐	☐	A total of ten (10) files were reviewed for 5 residential and 5 non-residential youth. Four (4) out of five (5) residential files and one (1) out of the five (5) non-residential files revealed that the service plan was developed within seven (7) working days of the needs assessment. Some deficiencies were noted with regards to the frequency of service and target dates being noted on all the plans. Signatures of youth, parent, and supervisor were also missing for some of the plans.	**Exception – Limited rating** • Five of ten files (One (1) residential and four (4) non-residential) revealed that the service plan was not developed within seven (7) working days of the needs assessment. • One (1) residential files is missing the frequency of services to be provided • Three (3) nonresidential charts are missing target dates • Three (3) case plans (1 residential and

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Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						All but one of the files (non-residential) has evidence of a service plan being developed. Case plan reviews were not evident in four of the files.	2 nonresidential are missing signatures of the youth • Five case plans (3 residential and 2 non-residential) were missing the signature of the parent – no progress notes were found to explain reason • Three case plans (2 residential and 1 non-residential) were missing the signature of the supervisor • One (1) non-residential file did not have an evidence of a service plan being developed • Four case plans (1 residential and 3 non-residential) had no evidence of 30-day reviews
2.04: Case Management and Service Delivery							
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						☒ YES ☐ NO (explain) Policy and procedures 2.04 addresses the requirement for case management and service delivery. The policy was last revised on 07/01/18 and signed and dated by the CEO and CPO.	No exceptions
RATING	☒	☐	☐	☐	☐	Total of ten (10) (5 residential and 5 non-residential) files were reviewed. All 10 files showed evidence that a counselor was actively involved with delivering services to clients and families. There was a direct relationship between the specific needs of each client/family and the development of their individual service plans. One (1) file (non-residential) was not applicable as the service plan was not developed or implemented. All 9 applicable files demonstrated coordination of services and referrals based on the needs assessed as well as monitoring youth's progress, providing support for the families, and referrals for case staffing (4 cases). Follow-ups were completed on time in 1 applicable closed file.	No exceptions

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Quality Improvement Indicators	Rating: Satisfactory	Rating (Explain): Deficiency Identified	Rating (Explain): No Eligible Items For Review	Rating (Explain): No Practice	Rating (Explain): Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						It was noted that one non-residential file had very few notes with the last one written on 9.19.19 with no follow-ups. Also, several of the notes for both residential and non-residential files reviewed did not include the time of service.	
2.05: Counseling Services							
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						☒ YES ☐ NO (explain) Policy and procedures 2.05 addresses the requirement for counseling services. The policy was last revised on 07/01/18 and signed and dated by the CEO and CPO.	No exceptions
RATING	☐	☒	☐	☐	☐	Total of ten (10) (5 residential and 5 non-residential) files were reviewed. All applicable files have case notes documenting counseling services and youths' progress. The supervisor has an ongoing internal process that ensures clinical reviews of case records and staff performance. Youth and families receive counseling service in accordance with their case/service plan, and the program provides individual/family counseling. The group counseling logs were reviewed from April 2019 until October revealing the following: The logs did not meet the requirements of having groups at least 5 times a week as the agency policy states that house meetings should not be considered a counseling group and majority of the group notes were just that. Many of the notes did not include topic, date, or the time, hence did not meet the criteria for group. The group form does not include a place to document duration to show the groups last at least 30 minutes.	**Exception** The group logs did not meet the requirements of having groups at least 5 times a week as the agency policy states that house meetings should not be considered a counseling group and majority of the group notes were just that. Too, many of the notes did not include topic, date, or the time, hence had to be eliminated from the count.
2.06: Adjudication/Petition Process							
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						☒ YES ☐ NO (explain) Policy and procedures 2.06 addresses the requirement for adjudication/petition process. The policy was last revised on 07/01/18	No exceptions

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Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						and signed and dated by the CEO and CPO.	
RATING	☒	☐	☐	☐	☐	The Case Staffing Committee is made up of DJJ representative, CINS/FINS provider, school representative, and Court Liaison. The committee may also include state district attorney, health, mental health representatives, or any person requested by the guardian(s), youth, or CINS/FINS staff. A signed, written report of the findings of the committee will be provided to the family at the conclusion of the meeting, or it can be mailed to them within 7 days after the Case Staffing. There was only one applicable case staffing conducted by the provider since the last QI review. The family and committee was notified of the case staffing date no less than 5 days prior to the staffing. The hardcopy case staffing form shows the signatures of the youth, parent, DJJ/CINS representative, school representative, and mental health professional.	No exceptions
2.07: Youth Records							
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						☒ YES ☐ NO (explain) Policy and procedures 2.07 addresses the requirement for maintaining confidential records. The policy was last revised on 07/01/18 and signed and dated by the CEO and CPO.	No exceptions
RATING	☒	☐	☐	☐	☐	All of the agency records are found in their EMR “Lauris”. From staff interviews it was gathered that there are no more paper charts. In the field, staff use tablets to access their EMR and the tablet is kept in a locked pouch. Former hard copy files are kept on-site in the secured, non-residential FSFF office building. The file cabinet is locked and marked “Confidential”.	No exceptions
2.08: Sexual Orientation, Gender Identity, Gender Expression							

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						☒ YES ☐ NO (explain) Policy and procedures 2.08 meets the requirement for ensuring a safe and therapeutic environment for youth regardless of sexual orientation, gender identity, and gender expression. The policy was last revised on 07/01/18 and signed and dated by the CEO and CPO.	No exceptions
RATING	☐	☒	☐	☐	☐	During a tour of the facility, "safe zone" rainbow flags were posted in the facility indicating that all youth are welcome and should feel safe regardless of sexual orientation, gender identity, and gender expression. The stickers were visibly observed in the lobby, on a poster board in each dorm, on the window and door of the intake office, on the counselors' office doors, and in the administrative office area. The program has four different types of brochures providing education and information about LGBTQ; two from the Alliance for LGBTQ, 1 in Spanish from the National Runaway Switchboard, and 1 from pridelines. Alliance occasionally conducts groups for the provider. The program served three youth who met the criteria for the indicator. One youth identified as female transgender, one lesbian, and one as bisexual. Documentation reviewed demonstrated the youth were addressed according to their preferred name and gender pronouns and preferred name and gender pronouns were used in the e-logbook records as well as case notes, and other client information. Youth preference was considered and documented for room assignment for two of the three youth on the CINS/FINS intake form but was blank for one of the youth; however, it was verified on the client bed assignment form that the transgender female youth was assigned a bed in the female dorm. Although the room assignment documented on the CINS/FINS Intake form does not identify which gender dormitory the youth are assigned (just the module and bed number),	**Exception** The program did not have documentation to support new staff being made aware/having knowledge of Florida Network policy #5.08. None of the 5 new staff training files reviewed confirmed a practice is currently in place.

Quality Improvement Indicators	Rating: Satisfactory	Rating – Explain: Deficiency Identified	Rating – Explain: No Eligible Items For Review	Rating – Explain: No Practice	Rating – Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						room assignments are also documented on the Client Daily Point Sheet Log and in the e-logbook during bed checks. None of the youth were identified as needing hygiene products and other items needed by the youth to support their gender identity or gender expression.	
2.09: Special Populations							
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						☒ YES ☐ NO (explain) Policy and procedure 3.07 addresses all the key elements of the QI indicator. The policy was last updated on 7/1/18 and was signed by the CEO and Chief Administrative and Compliance Officer.	No exceptions
RATING	☐	☒	☐	☐	☐	The provider did not serve any youth who met the criteria for Staff Secure, DMST, Intensive Case Management, or FYRAC since the last QI review. Three (3) DV Respite files were reviewed for this indicator. All three (3) files had documentation of youth pending DV charges and had evidence of being screened by JAC/Detention and did not meet the criteria for secure detention. All three (3) youth in the program did not have a length of stay in DV Respite placement that exceeded the 21 days. The case plans reflected goals consistent with the issues identified regarding aggression, coping skills and effective communication in 2 of the 3 files. Although discharge notes in 2 of the files indicated youth received individual/family and group counseling during care, no progress notes or other documentation was documented to support these services were provided, consistent with all other general CINS/FINS program requirements. One applicable probation respite file was reviewed. Documentation in the file demonstrated the referrals came from DJJ Probation; the length of stay was less than 30 days, there is evidence that all case management services and counseling needs were considered, and services are provided to the PR youth are consistent with all other	**Exception** Two of the files indicated youth received individual/family and group counseling during care; however, there were no progress notes or other documentation to support these services were provided, consistent with all other general CINS/FINS program requirements. In fact, none of the three files reviewed had any progress notes documenting services provided. One of the 3 files did not have a case plan developed.

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Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						general CINS/FINS program requirements.	
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						☐ YES ☐ NO (explain) ☒ N/A (explain)	Miami Bridge is not a SNAP provider.
RATING	☐	☐	☐	☐	☒	**N/A** Miami Bridge is not contracted to provide SNAP services.	**N/A**

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STANDARD 3: SHELTER CARE

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
Standard Three – Shelter Care							
3.01 Shelter Environment **The shelter's environment is safe, clean, neat and well maintained. The program provides structured daily programming to engage youth in activities that foster health, social, emotional, intellectual and physical development.**							
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						☒ YES ☐ NO (explain) The agency has a policy and procedure in place, 3.01 Shelter Environment that addresses the indicator. The policy was signed and dated on 7/1/2018 by the CEO and Chief Program Officer.	No exceptions
RATING	☐	☒	☐	☐	☐	The agency has current licenses and Inspections. The following were reviewed: DCF Child Care License- 6/1/19 Annual Fire Safety Inspection- 10/1/19 Residential Group Care- 9/24/19 Food Service- 10/1/19 A tour of the interior and exterior of the facility was conducted. The facility was observed to be clean and well maintained. The dorm style youth sleeping areas were clean and organized. Each youth has ample space for their belongings as well as a lockable place to store additional belongings. There is a daily programming schedule posted in the dayroom which shows opportunities for educational activities, clinical groups and recreational activities. One youth was interviewed and expressed feeling safe and supported at the facility. The youth was able to discuss various educational and recreational activities provided at the facility as well as within the community. The exterior was observed to be clean and free of debris and hazards. There is new landscaping and a privacy fence around the exterior. The	**Exception** There was no fire drill conducted on the second shift in June 2019. There was no fire drill conducted on second and third shift in August 2019. Two of the fire drills exceeded the recommended evacuation time of 2 minutes. The fire drill conducted in June on the third shift was (5) five minutes and the drill conducted in July on third shift was (8) eight minutes.

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						agency's CEO reported the exterior renovations were provided by Motorola as part of their day of caring.	
3.02: Program Orientation							
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						☒ YES ☐ NO (explain) The agency has a policy and procedure in place, 3.02 for program orientation that addresses the requirement of the indicator. The policy was signed and dated on 7/1/2018 by the CEO and Chief Program Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of 3 closed residential files were reviewed as the program did not have any current open/active CINS/FINS youth. All files reviewed demonstrated youth receiving a comprehensive orientation and handbook provided within 24 hours. Two (2) of three (3) of the residential files had clear suicide prevention alert notifications. All files that were reviewed demonstrated all program orientation requirements as outlined in the CINS/FINS policy manual. Signatures of youth with parent/guardian were obtained, daily activities were reviewed and the Abuse Hotline number was provided.	No exceptions
3.03: Youth Room Assignment							
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						☒ YES ☐ NO (explain) The agency has a policy and procedure in place, 3.03 for room assignment that addresses the requirement of the indicator. The policy was signed and dated on 7/1/2018 by the CEO and CACO.	No exceptions
RATING	☒	☐	☐	☐	☐	A review of four client files, two open and two closed, was conducted for four youth. Each of the files had pertinent information for appropriately assigning youth to a room/bed. Youth's classification determines where they're placed in the dorm. Youth on sight and sound are always placed on a bottom bunk. Additionally, youth	No exceptions

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Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						classified as staff secure are always placed closest to the door where staff are posted for a heightened level of supervision.	
3.04: Log Books							
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						☒ YES ☐ NO (explain) The agency has a policy and procedure in place, 3.04 for logbooks that addresses the requirement of the indicator. The policy was signed and dated on 7/1/2018 by the CEO and CACO.	No exceptions
RATING	☒	☐	☐	☐	☐	During the current review period, the agency utilized the manual logbook as well as the electronic logbook. The agency has procedure in place for both platforms. The agency uses a highlight system for the manual logbook which is consistent and easy to follow. The highlight system helps to distinguish and track significant activity. The occurrence of fire drills, youth movement and critical incidents was documented, highlighted and the designated color was used throughout logbook. Those activities which could impact the security and safety of the program is highlighted in red. Supervisors and direct care staff read at least the previous two shifts in order to gain awareness of any unusual occurrences. Supervisory review is highlighted in green in the manual logbook. House census and room assignments will be noted at the beginning of each shift and is also highlighted in green. In the E-Logbook icons are available to track significant activity. Staff are not utilizing the icon feature consistently. However, all significant activity is being documented.	No exceptions
3.05: Behavior Management Strategies							
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						☒ YES ☐ NO (explain) The agency has a policy and procedure in place, 3.05 for behavior management strategies that address the requirement of the indicator. The policy was signed and dated on 7/1/2018 by the CEO and CACO.	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
RATING	☒	☐	☐	☐	☐	Miami Bridge utilizes a Behavior Management System (BMS) that is based on a system of rewards, privileges, and consequences. The system encourages positive behavior and discourages negative behavior. The shelter supervisor monitors the use of behavioral interventions by Youth Activity Workers as well as the use of the point/level system. YAWs will document and report youth behaviors. Positive behaviors allow youth to earn points and negative behaviors result in the loss of points. Youth can earn points for completing daily tasks such as completing chores and hygiene. Youth can also earn points for positive behaviors in the community while on outings. The BMS provides a tool to help staff determine if the individual youth is meeting behavioral expectations as well as their ongoing progress. The BMS consists of a point and level system that rewards BMS privileges and consequences are clearly defined at intake and posted in the facility for review by youth and is discussed during house meetings. This reviewer spoke with youth and staff about how the BMS is implemented. Staff explained how the system is used as well as how youth respond to the system. Staff reported that the system is most effective when it is utilized consistently across all shifts. A youth was interviewed and was able to articulate and understanding of the BMS. Youth stated the system was fair and easy to understand.	No exceptions
3.06: Staffing and Youth Supervision							
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						☒ YES ☐ NO (explain) The provider has policies in place, 3.06-Staffing and Youth and Staff Supervision and 3.06.01-One on One (1:1) Staff/Client Supervision, to ensure adequate staffing is provided to ensure the safety and security of youth and staff. These policies were last reviewed and approved 7/1/18 and signed by the CEO and the CPO.	No exceptions

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Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
RATING	☐	☒	☐	☐	☐	A review of the program's surveillance system was conducted on three separate days, October 14th, 15th and 16th. The review was conducted in the presence of the Shelter supervisor and the QI and training coordinator. The review revealed violations to the agency policy in which staff are to perform bed checks at least every 15 minutes in real time while clients are in their dormitories asleep, or when sick or other times when in their room sleeping. As well as to the program's stated practice in which staff are to make entries into the E-logbook every 15-minutes. Shelter supervisor stated staff are expected to walk to the office where the logbook is kept allowing staff covering the male and female dorms opportunities to make entries. The surveillance system operates on motion sensors and all staff movement to the office activates the system.	**Exception – Limited rating** On October 14th, bed checks were documented at 1:20 am, 2:16 am, 2:37 am, 3:15 am, 3:48 am, 4:43 am, 5:13 am and 5:46 am thus failing to comply with the required 15-minute increments. On October 15th, there were no bed checks observed on video from 2 am until 6am on the female side of the dorm. However, there is documentation indicating checks were conducted at 2:13 am, 3:54 am, and 5:21 am. Additionally, on 10/15, a bed check on the boys' side of the dorm was observed at 12:41 am and documented at 12:49. A second bed check was documented at 2:13 am; however, the check observed on camera was performed at 2:38 am. Another bed check on the boys' side of the dorm was observed on camera at 3:30 am and not documented until 3:54 am. On 10/16, bed checks in the boy's dorm were documented at 1:02 am, 1:41 am, 2:35 am, 3 am, 4 am, 4:23 am, 4:50 am and 5:57 am again failing to comply with the required 15-minute checks. Two staff members who worked on the nights reviewed were interviewed. Both admitted to making entries for the other person and signing for the person. However, the documentation does not clearly indicate the

Quality Improvement Indicators	Rating	Explain				Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
							entry was made on behalf of the other staff with permission.
3.07: Video Surveillance System							
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						☒ YES ☐ NO (explain) Policy and procedure 3.07 addresses all the key elements of the QI indicator. The policy was last updated on 7/1/18 and was signed by the CEO and CACO.	No exceptions
RATING	☒	☐	☐	☐	☐	The program has cameras in the interior and exterior to cover all general locations. Hallways that lead to where youth sleep, areas youth and staff congregate and where visitors enter, and exit are all covered. The surveillance system can store video for a minimum of 30 days. The agency has a practice in place in which video is made available within 24-72 hours for the purposes of investigating allegations of incidents and to accommodate quality improvement visits. Supervisory review is conducted bi-weekly and documented to assess the activities of the facility to include a review of a random sample of overnight shifts. The agency maintains a list of designated personnel who can access the surveillance system.	No exceptions

STANDARD 4: MENTAL HEALTH/HEALTH SERVICES

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
Standard Four – Mental Health /Health Services							
4.01: Healthcare Admission Screening							
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						☒ **YES** ☐ **NO (explain)** Policy and procedure 4.01 addresses all the key elements of the QI indicator. The policy was last updated on 7/1/18 and was signed by the CEO and CPO.	No exceptions
RATING	☒	☐	☐	☐	☐	Youth are screened by the on-site registered nurse (RN) or non-licensed medical staff to identify if a youth is on any current medications, have any existing medical conditions to include chronic conditions, allergies, have any recent illness or injuries. The RN will follow-up on any medical screenings performed by non- licensed medical staff. The program utilizes the CINS/ FINS Intake Screening Form to document any health issues, medical conditions, and medications a youth may have. Any youth currently on medication at the time of admission is documented on the Medication Management Issue form. If a youth displays a serious or chronic condition or emergency which requires immediate medical services, the program utilizes a Medical Treatment Form to make arrangements for additional medical services and ensure all necessary follow-up is completed. A review of four youth files was conducted and each had documentation to support the program followed general procedures and practice of the Health Care Admission Screening. Each applicable youth filed had the physical health care form completed upon intake admission.	No exceptions
4.02 Suicide Prevention							

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Quality Improvement Review

Miami Bridge Central – October 23-24, 2019
Lead Reviewer: Marcia Tavares

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
There is a written plan that details the program's suicide prevention and response procedures. The plan complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.							
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						☒ **YES** ☐ **NO (explain)** Policy and procedure 4.02 addresses all the key elements of the QI indicator. The policy was last updated on 7/1/18 and was signed by the CEO and CPO.	No exceptions
RATING	☒	☐	☐	☐	☐	Four youth mental health records were reviewed and each contained a suicide screening form completed within twenty-four hours of the youth's admission. All reviewed record contained the results from the screening form and were signed by the supervisor. Each of the four youth were placed on constant sight and sound supervision until assessed by a licensed or non-licensed professional under the direct supervisor of the licensed professional and were placed on the appropriate level of supervision based on the results of the suicide screening form. Each reviewed observation Logs indicated staff documented observations every fifteen minutes which included an observation of warning signs, and youth behavior and the log contained the date, time and initial of the staff supervising the youth. In each instance, the youth remained on the appropriate level of supervision until seen by a licensed professional or a non-licensed professional under the supervision of the licensed professional.	No exceptions
4.03: Medication							
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						☒ **YES** ☐ **NO (explain)** Policy and procedure 4.03 addresses all the key elements of the QI indicator. The policy was last updated on 7/1/18 and was signed by the CEO and CPO.	No exceptions

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RATING	☒	☐	☐	☐	☐	Observation of the medical office confirm the medications was stored in Pyxis Med-Station 4000 and the medication cabinet is inaccessible to youth, the program maintains a minimum of two super users for the med-station, the temperature require are appropriate, and shift to shift counts are conducted and documented for controlled substances. The program does not accept any youth prescribed injectable medication except for epi-pens. A review of the Medication Distribution Log book indicated the program staff conducted medication counts daily on each of three shifts and maintains a perpetual inventory with an accurate count for controlled substances. Any medication discrepancies are cleared prior to the end of each shift. The program has a small secured refrigerator located in the nurse office designated for medication requiring refrigeration. There was no incident reported to the Central Communication Center (CCC) during this review period related to youth medication distribution. The program has a list of designated staff delineated in user permission s have aces to	No exceptions
4.04: Medical/Mental Health Alert Process							
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						☒ **YES** ☐ **NO (explain)** Policy and procedure 4.04 addresses all the key elements of the QI indicator. The policy was last updated on 7/1/18 and was signed by the CEO and CPO.	No exceptions
RATING	☒	☐	☐	☐	☐	The program has developed and implemented an alert system to identify youth with nutritional, substance abuse, medical and mental health issues. The alert system is a color-coded system which is communicated to staff through the program logbook, the alert board which is in the intake office and documented in the youth's individual healthcare file. The licensed registered nurse (RN) conducts an initial healthcare screening to determine and document if a youth has a medical, dental or mental health issue. If a non-licensed medical staff conducts the screening, the RN will review the screening form within seventy-two hours. All direct care program staff are required to review	No exceptions

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						medical and mental health information of the youth in the program Reviewed four medical and mental health alert records confirmed each youth has a medical or mental health conditions or food allergies and was appropriately placed on the alert system. The program also maintains a medical alert board located in the intake office which identifies medical, mental health, substance abuse, and nutrition alerts. The program also maintains special nutritional diet alerts for youth with dietary restrictions located on a clip board in the kitchen. Formal interview with the registered nurse and health care specialist confirmed this practice.	
4.05: Episodic/Emergency Care							
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						☒ **YES** ☐ **NO (explain)** Policy and procedure 4.05 addresses all the key elements of the QI indicator. The policy was last updated on 7/1/18 and was signed by the CEO and CPO.	No exceptions
RATING	☒	☐	☐	☐	☐	A review of three youth records indicated each youth who received a referral for off-site emergency care had all the required documentation. Each record contains the incident report, verification receipt of medical clearance discharge instructions with follow up in the file, and notification to the parent/guardian. Observation of the program's suicide response kit found the program has five knife-for-life and wire cutters located in the intake office, admissions office, kitchen, school classroom, and reception area. There are six first aid kits located throughout the program. Two are in the vehicles used to transport youth, one in the intake office, one in the kitchen, one in the admission office, one in the reception area, and one in the school classroom. First aid kits are checked weekly by the nurse and replenished when needed.	No exceptions

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						A review of training records verified each staff received first aid, cardiopulmonary resuscitation (CPR), and AED training. Formal interview with the registered nurse and health care specialist confirmed the program emergency medical and dental services are provided by Miami Dade County Emergency Medical Service (EMS) and the program inter-agency agreement is with Camillus Health Co. this practice.	