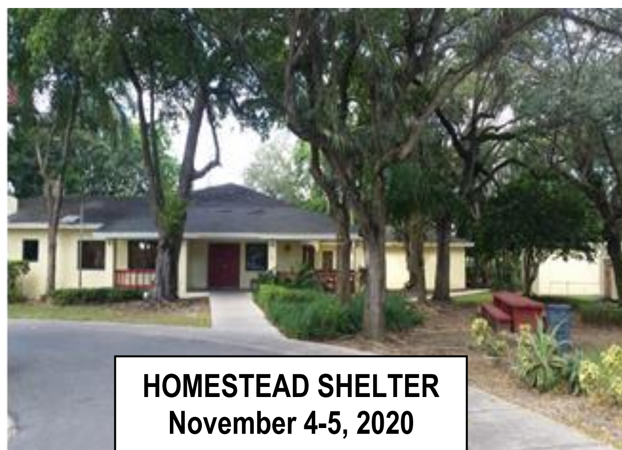
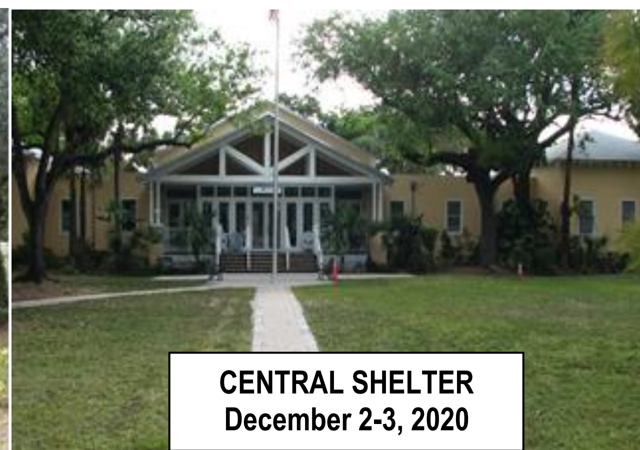
Florida Network for Youth and Family Services Compliance Monitoring Report for





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 2020-2021 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 2020 through June 30, 2021.

The reviews were conducted by Marcia Tavares, Consultant for Forefront LLC and Peer Reviewers. Agency representatives from Miami Bridge present for both entrance interviews were: Dorcas Wilcox, Chief Executive Director; Alicia Sherman, Director of Finance; Emilio Vento, Chief Program Officer; David Sharfman, Chief Business Officer; Roxana Campos, Senior Director Behavioral Services; Lashonda Chavis, Director of Admissions; Tracy Scott, RN/Homestead Shelter Director; and Richard Rabathaly, QI/Training Manager. Additional staff in attendance includes supervisors, clinical staff, and health care specialists who were present at their program specific entrance conferences. The last onsite QI visits were conducted October 23, 2019 at the Central location and November 6, 2019 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 91% for achieving full compliance with 10 of the 11 applicable indicators** of the CINS/FINS Monitoring Tool. Two of the thirteen indicators were not applicable because: 1) the provider does not have any outstanding corrective action item(s) cited by an external funding source, and 2) does not have any current inventory purchased with DJJ/FN Funds. There were no corrective actions as a result of the monitoring visit; however, one (1) recommendation was made for an indicator rated as conditionally acceptable.

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

2020-2021 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 11-04-2020-2021

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): December 2-3, 2020 (Central) and November 4-5, 2020 (Homestead)**

Major Programmatic Requirements	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
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. Both Mr. Rabathaly and Ms. Chavez are scheduled to participate in QI reviews for FY 2020-2021.	
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 nine additional funding sources for FY 2020-2021 was provided. The list included funders such as the Roblee Foundation, Children's Trust, United Way, MDC CDBG, Miami Foundation, Denise Moon, Sash & LGBTQ, Our Funds, and Department of Health and Human Services. The provider also maintains an extensive list of over 38 MOUs with community agencies who provide medical, mental	

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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)
						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 12/27/19-12/27/2020 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 12/27/19-12/27/2020 Workers Compensation insurance is provided through NY Marine General Insurance Co. with limits of $500,000 each/ $500,000 aggregate, effective 12/27/19-12/27/2020	

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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)
						The provider also has an Umbrella policy through Philadelphia Indemnity Insurance Company, for limits of coverage $1,000,000 each and aggregate, effective 12/27/19-12/27/2020 and Management Liability insurance through Arch Insurance Company with limits of coverage $1,000,000 aggregate, effective 1/1/2020-1/1/2021. 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**	☐	☐	☐	☐	☒	Interview: During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by any external funding sources.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: A copy of the agency's Fiscal Policies and Procedures was received onsite (Section 7 of the agency's SOPs). The procedures appear to follow general GAAP guidelines and include procedures for: Financial Planning and Reporting; Internal Control; General Accounting and Records; Cash and	

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	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
						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**	☐	☐	☒	☐	☐	Documentation: 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 (200 Florida Network) 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 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.	

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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)
						The GL for the CINS/FINS Program for the period July 1-October 26, 2020 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 sign a Cardholder Responsibilities Agreement with the agency. Per the P&P, the limit on the P card is $600 for Shelter Directors.	

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						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. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☒	☐	☐	☐	Documentation: Bank Statements and Reconciliation Reports for the period April 1-September 30, 2020 for the provider's Operating Bank account with TD Bank were reviewed. Based on a review of these documents, it appears that 2 of the 6 bank reconciliations for July and September's bank statements were	**Recommendation: 1)** The printed date on reconciliation reports for the months of July and September 2020 are greater than 6 weeks from the end of the corresponding month being reconciled. The provider's policy states bank reconciliations will be completed by the 15th day of the following month and contract

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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)
						prepared greater than 6 weeks of receipt of the bank statement, 10/6/20 and 12/3/20, 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.	requirement for reconciliation is within 6 weeks of receipt of the bank statement.
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 retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Federal 941 payments are being prepared, processed, and submitted timely semi-weekly through the authorized contracted reporting agent Dominion Payroll. The payroll	

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						payments are processed electronically by Dominion. Copies of the provider's 941s for the 1st, 2nd, and 3rd quarters of 2020 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**	☐	☐	☒	☐	☐	Documentation: Agency provided Budget vs. Actual report for the period July through October 26, 2020 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 $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: As of the date of the onsite visit November 2020, 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 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	

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						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**	☐	☐	☒	☐	☐	Documentation: 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 10 of the 11 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the thirteen indicators were not applicable because: 1) the provider does not have any outstanding corrective action item(s) cited by an external funding source, and 2) does not have any current inventory purchased with DJJ/FN Funds. Consequently, **the overall compliance rate for this contract monitoring visit is 91%.** 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.

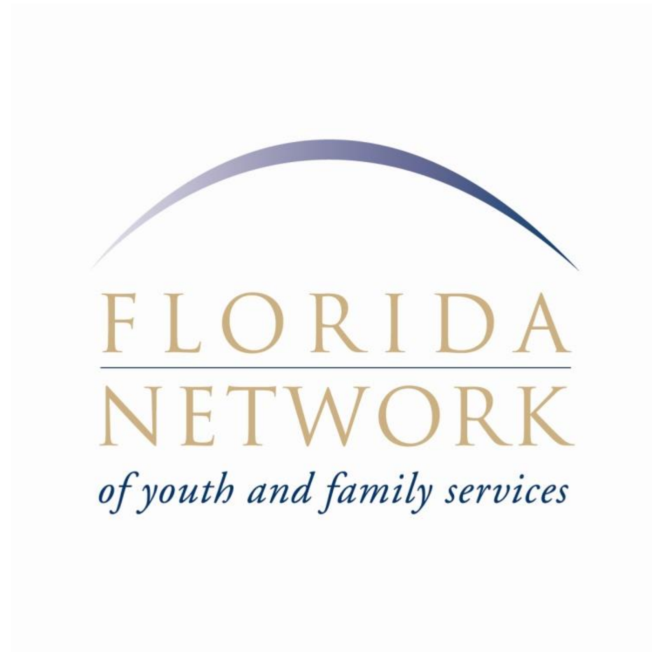
SUMMARY OF RECOMMENDATIONS

Recommendation (1)

Two of the six bank reconciliations for the months of July and September were prepared on 10/06/20 and 12/03/20, 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. The provider's policy also states bank reconciliations will be completed by the 15th day of the following month.

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 Youth and Family Services
Homestead, Florida
Residential Program

November 4-5, 2020

Compliance Monitoring Services Provided by

Quality Improvement Review

Miami Bridge Homestead– November 4-5, 2020
Lead Reviewer: Marcia Tavares

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
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: 100.00%
Percent of indicators rated Limited: 0.00%
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	Limited
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Failed
3.07 Video Surveillance System	Limited

Percent of indicators rated Satisfactory: 57.14%
Percent of indicators rated Limited: 28.57%
Percent of indicators rated Failed: 14.29%

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: 89.29%
Percent of indicators rated Limited: 7.14%
Percent of indicators rated Failed: 3.57%

Rating Definitions

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

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

Reviewer

Members

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

Paula Friedrich - Department of Juvenile Justice

Raymond Ballinger – Lutheran Services Florida Southeast

Ben Kemmer – Florida Keys Children Shelter

Shareet Pennino - Lutheran Services Florida Southwest

FLORIDA NETWORK of youth and family services

Quality Improvement Review

Miami Bridge Homestead– November 4-5, 2020
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, and (3) Shelter Care/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2019).

Persons Interviewed

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

Documents Reviewed

☐ Accreditation Reports	☒ Table of Organization	☒ Vehicle Inspection Reports
☒ Affidavit of Good Moral Character	☒ Fire Prevention Plan	☐ Visitation Logs
☒ CCC Reports	☒ Grievance Process/Records	☒ Youth Handbook
☒ Logbooks	☐ Key Control Log	4 # Health Records
☒ Continuity of Operation Plan	☒ Fire Drill Log	4 # MH/SA Records
☐ Contract Monitoring Reports	☒ Medical and Mental Health Alerts	10 # Personnel /Volunteer Records
☐ Contract Scope of Services	☒ Precautionary Observation Logs	7 # Training Records
☒ Egress Plans	☒ Program Schedules	14 # Youth Records (Closed)
☒ Fire Inspection Report	☒ Supplemental Contracts	12 # Youth Records (Open)
☐ Exposure Control Plan	☐ Telephone Logs	_ # Other:

Surveys

5 # Youth	18 # Direct Care Staff	0 # Other: _____

Observations During Review

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

Comments

Due to COVID-19, this review was conducted **on-site and virtually**.

Overview

Monitoring Purpose:

The purpose of this monitoring is to provide an annual quality improvement program review. This is to verify the agency adheres to all current CINS/FINS standards and contract compliance requirements for residential and non-residential services.

Strengths and Innovative Approaches

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 Central 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 2019, Miami Bridge has been faced with challenges related to the pandemic; nevertheless, the agency has experienced growth and opportunities to enhance services to youth and families as follows:

STAFFING

A two phase staffing transformation – Part I (Administration)

- Reconstruct C Suite for future growth

- Previous Chief Program Officer/Chief Administrative Officer (CAO) were temporarily consultant roles; a new Chief Program Officer was hired in June 2020 and agency is looking to fill CAO to complete suite
- New licensed Sr. Director was hired in September 2020
- More therapeutic approach in anticipation of implementation of Family First Prevention Services Act (FFPSA)/Qualified Residential Treatment Program (QRTP)
- Agency is seeking more licensed personnel to enhance clinical services

Staffing Transformation – Part II (Direct Services)

- Switch to ADP for Payroll Services - HR/Workforce Assist
- Onboarding of HR Specialist pending hiring of
- Staff Surveys were distributed in October and responses will be reviewed by management soon
- Power Circle (CEO meets with staff for feedback)
- Staff of the Month and WOW Awards were implemented to acknowledge high performing staff
- Track Suits/Company shirts are ordered for staff

COVID - 19
COVID Challenges/Support

- Staffing issues/decrease in youth as agency grapples with virus
- Engagement/Interaction in Community (a lot less trips)
- More Zoom Calls/interaction with community
- Agency garnered community support with PPEs
- Strong leadership with medical staff

FUNDRAISING
Fundraising Concerns (loss of $300,000)

- Annual Gala cancelled
- Annual luncheon cancelled
- Annual Physician’s Fishing Tournament

Fundraising Substitutions/Donations

- Give Miami Day
- City National Bank
- HHS
- Holiday Drive by Event (PepsiCo)

PARTNERSHIPS

Increased partnerships with Government

- HHS Basic Center Grant - $600,000 (over three years)
- Host Homes Pilot Program (18 to 21 year old group) - $200,000
- City of Miami - $50,000
- County Commissioner Eileen Higgins - $17,500

Partnerships

Community partnership with iCount – creates youth access point for Miami-Dade Homeless Trust

Notable Grants:

LGBTQ Program (Roblee)

Data Manager (SASH funding) to assist with EMR, E-log

PROJECTS

Other Projects:

- Strategic Plan (Four year)
- COA Reaccreditation underway for 2021 certification expiration
- Powerful Social Media (marketing & videographer for TV coverage, articles published, monthly newsletter, over 2K followers)
- Agency is re-doing Miami Bridge History to reflect knowledge of its true founder Richard Moran and original history

Narrative Summary

MB Homestead, located at 326 NW 3rd Ave, Homestead, Florida, and is under the leadership of a Board of Directors, Chief Executive Director, Director of Finance, Chief Programing Officer, Chief Business Officer, Director of Admissions, Director of Behavioral Services, QI/Training Manager, and 2 Shelter Managers, one of which is also the program's Registered Nurse. The Chief Executive Director oversees Miami Bridge and services provided in Central Miami and Homestead, Florida. Other vacant positions include a HR Specialist; some vacant direct care positions are on hold as a result of reduced youth census.

MB Central office handles all fiscal, administrative, and personnel functions for both locations. The Central location has 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 overall findings for the QI review for Miami Bridge Homestead is summarized as follows:

Standard 1 has a total of seven indicators regarding Management Accountability. Five of the seven indicators in Standard 1 were rated satisfactory with no exceptions (1.01, 1.02, 1.03, 1.05, and 1.07) and two were rated satisfactory with exceptions (1.04 and 1.06).

Standard 2 has a total of ten indicators that relate to intervention and case management. One of the indicators – SNAP is not applicable as Miami Bridge is not a SNAP provider. Six of the nine applicable indicators were rated satisfactory with no exceptions (2.01, 2.02, 2.04, 2.07, 2.08, 2.09) and three were rated satisfactory with exceptions (2.03, 2.05, and 2.06).

Standard 3 has a total of seven indicators regarding shelter care. Three of the seven indicators were rated satisfactory with no exceptions (3.02, 3.03, 3.05), one was rated satisfactory with exception (3.01), two were rated Limited (3.04 and 3.07) and one received a Failed rating (3.06).

Standard 4, Mental Health and Health Services, is comprised of five indicators. All five indicators were rated satisfactory with no exceptions.

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

Standard 1: None of the indicators in Standard 1 had a Limited or Failed rating.

Standard 2: None of the indicators in Standard 2 had a Limited or Failed rating.

Standard 3:
Indicator 3.04 – Limited
The program's policy and procedure requires supervisory reviews of logbooks weekly; however, the electronic logbook indicated supervisory reviews occurred only eight times since December 4, 2019. Additionally, six of the eight supervisory reviews did not notate whether any deficiencies were observed.

Indicator 3.07- Limited
Supervisory reviews of video surveillance footage are required to be conducted at least once every fourteen days; however, the electronic logbook indicated supervisory reviews occurred only eight times since December 4, 2019.

Indicator 3.06 – Failed
A review was conducted of provided video surveillance footage clips recorded between 12:00 a.m. and 4:00 a.m. on October 10, October 14, October 18 and October 30 which revealed bed checks were not consistently conducted at least every fifteen minutes while youth were in their sleeping rooms. The program received a Limited rating for this indicator during the last QI review and failed to demonstrate proficiency during this subsequent review. Due to the critical nature of this indicator with regards to youth supervision and safety, this indicator is rated as Failed.

Standard 4: None of the indicators in Standard 4 had a Limited or Failed rating.

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CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
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 was last revised 10/24/19 by the CEO.	
a. Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth.	☒	☐	☐	☐	☐	The program implemented use of the Berke pre-employment suitability assessment November 6, 2018 and established a pass rate of medium-high. Five new staff were hired during the review period but two were exempt from completing the Berke as one is a Program Director and the other has a master's degree. The assessment was administered to 3 applicable new staff prior to hire, two of which received a low score on the assessment. No documentation was provided to support the hiring of staff with sub-score results.	
b. Background screening completed prior to hire/start date or exemption obtained prior to working with youth (if rated ineligible) for new hires, volunteers/interns, and contractors	☒	☐	☐	☐	☐	A total of 9 background screening files were reviewed for 5 new hires and four interns. All nine background screenings were completed prior to start dates of the new hires and interns.	
c. Five-year re-screening completed every 5 years from initial date of hire	☒	☐	☐	☐	☐	The program had one applicable 5-year rescreening during the review period. A 5-year rescreening was submitted on time with evidence of DJJ Clearinghouse valid retained prints date.	

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Miami Bridge Homestead– November 4-5, 2020
Lead Reviewer: Marcia Tavares

Quality Improvement Indicators	Rating	Explain				Review Based Upon	Notes
	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	**Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
d. Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	☒	☐	☐	☐	☐	Provider emailed the Annual Affidavit of Compliance with Level 2 Screening form to DJJ BSU on 1/7/2020 prior to the deadline.	
e. Proof of E-Verify for all new employees obtained from the Department of Homeland Security	☒	☐	☐	☐	☐	E-verify and proof of employment authorization is on file in all five employee's record.	
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) Policies and procedures 1.02 (Abuse Free Environment) and 1.02.01 (Grievance Process) were last revised and signed by the CEO on 7/01/18.	
Abuse Free Environment							
a. Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	☒	☐	☐	☐	☐	Miami Bridge's new employee handbook includes the code of conduct and an acknowledgement of receipt for employees to sign. The signed acknowledgement goes in the employee's personnel file.	
b. Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	☒	☐	☐	☐	☐	During a tour of the facility, the Florida Abuse Hotline number was observed to be posted in the day room, counseling hallway, and in each dormitory. All calls to the Abuse Hotline are documented in the program logbook.	
c. Youth were informed of the Abuse and Contact Number (see youth survey results)	☒	☐	☐	☐	☐	Youth are given a copy of the youth handbook during orientation which includes the abuse hotline information. Abuse hotline information is included on the orientation checklist in 4 youth files reviewed and is reviewed during orientation. Two youth surveyed indicated knowledge of the location of the abuse hotline number in the facility.	

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Lead Reviewer: Marcia Tavares

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
d. Management takes immediate action to address any incidents of threats or abuse	☐	☐	☒	☐	☐	No incidents of abuse or threats by staff needing management action was identified and/or reported during the review period.	
Grievance Process							
a. Agency has a formal grievance process	☒	☐	☐	☐	☐	The agency's grievance policy 1.02.01, reviewed and signed by the CEO on 7/01/18, meets the requirements of the indicator.	
b. Locked box accessible to only management and available to youth in a common area	☒	☐	☐	☐	☐	During the facility tour, a locked grievance box and grievance forms were observed to be mounted in the dayroom. The key for the grievance box is only accessible to management.	
c. Direct care does not handle the complaint/grievance unless assistance is asked for by the youth	☒	☐	☐	☐	☐	Per the shelter manager, direct care workers do not handle the complaints/grievance documents. Youth are instructed to place them in the grievance box.	
d. 72-hour resolution requirement by management	☒	☐	☐	☐	☐	Two grievance reports were reviewed: one was documented and resolved within the 72-hour timeframe. The second grievance was anonymous and was handled to the best of the program's ability.	
e. Grievance maintained on file for a minimum of 1 year	☒	☐	☐	☐	☐	Grievances are maintained in a binder for a minimum of one year.	
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 was last revised and signed by the CEO on 7/01/18.	
a. During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any	☒	☐	☐	☐	☐	Over a six-month period, the program reported four CCC incident reports. All incidents were reported within the 2-hour timeframe.	

Miami Bridge Homestead– November 4-5, 2020
Lead Reviewer: Marcia Tavares

Quality Improvement Indicators	Rating					Review Based Upon	Notes
		Explain					
	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	**Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
reportable incident occurred or within two hours of the program learning of the incident							
b. The program completes follow-up communication tasks/special instructions as required by the CCC	☒	☐	☐	☐	☐	Updates and follow-ups were documented and reported on 3 applicable incidents as requested by CCC.	
c. Incidents are documented in the program logs and on incident reporting forms	☒	☐	☐	☐	☐	All 4 incidents were documented in the program log and on incident reporting forms.	
d. All incident reports are reviewed and signed by program supervisors/directors	☒	☐	☐	☐	☐	All 4 incident report forms reviewed are signed by program supervisor or director.	
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 was last revised on 7/1/18 and signed by the CEO.	
First Year Direct Care Staff							
a. Direct care staff receives all mandatory training during the first 120 days of employment	☒	☐	☐	☐	☐	Three (3) first year direct care staff training files were reviewed. One of the three had completed more than the required 80 hours of trainings and the other two staff are on target for completing the 80 hours. All three staff completed mandatory training required in the first 120 days.	
b. Direct care staff completes all mandatory Florida Network and SkillPro training during the first year employment.	☐	☐	☒	☐	☐	The provider has only 3 first year staff for the review period; all 3 are still within the 1st year with time remaining to complete required training.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
a. Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training	☐	☐	☒	☐	☐	The program does not have any non-licensed mental health clinical shelter staff hired during the review period.	
b. Documentation of non-licensed mental health clinical staff person's training in Assessment of	☐	☐	☐	☐	☒	**N/A**	

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Quality Improvement Indicators	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).							
In-service Direct Care Staff							
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	☐	☒	☐	☐	☐	Four in-service staff files reviewed exceeded the 40 hours required. One of the four staff's First Aid/CPR expired on 8/28/2020. Upon notification, the staff completed the CPR/First Aid certification during the QI review.	**Exception** As required, valid First Aid/CPR certification was not maintained for a period of 2 months for one of the program's shelter youth care staff. Upon notification, the staff completed the CPR/First Aid certification during the QI review.
Required Training Documentation							
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.	☒	☐	☐	☐	☐	All 7 training files provided documentation of all trainings, date completed, and hours. Training certificates and training worksheets are also included in the training files.	
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 procedure #1.05 was last reviewed on 7/1/18 and approved by the CEO.	
Quarterly Reviews							
a. Case record review reports demonstrate reviews are conducted quarterly, at a minimum	☒	☐	☐	☐	☐	Peer record reviews were conducted Feb 2020 (Q1, Q2) and Oct 2020 (Q3, Q4) for FY 19-20. Record reviews for the 1st quarter FY2020-2021 was not yet completed but is scheduled later in the month of November 2020.	

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Quality Improvement Review

Miami Bridge Homestead– November 4-5, 2020
Lead Reviewer: Marcia Tavares

Quality Improvement Indicators	Rating	Explain				Review Based Upon	Notes
	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	**Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
b. The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	☒	☐	☐	☐	☐	The CQI committee meets to review program operations and performance including incidents, grievances, medication, health and safety, licensing, training, EMR, technology, and survey results when they are completed during the period. Trends and issues are discussed at these meetings as well as staff and Director's meetings. A review of agendas and meetings held in 2020 for the months of February, May, June, August, September, and October supported this practice.	
Annual Reviews							
a. The program conducts an annual review of customer satisfaction data	☒	☐	☐	☐	☐	The program's annual review of youth satisfaction surveys for FY19-20 is delayed due to the FN Dashboard being down. Youth surveys were completed for FY 2019-2020 in November 2019 and is scheduled for the next Director's meeting on 11/10/20. Staff surveys were administered in October 2020 and are also scheduled to be reviewed 11/10/20.	
b. The program conducts an annual review of outcome data	☒	☐	☐	☐	☐	Directors and CQI committee meetings are held regularly to review program outcome data. A review was conducted of agendas and meetings held in February and September 2020.	
Monthly Reviews							
The program conducts a monthly review of NetMIS data reports	☒	☐	☐	☐	☐	Netmis data reports are reviewed at Directors as well as staff meetings. A review of agendas and meetings held in 2020 for the months of May, June, August, September, and October supported this practice.	
Quality Improvement Process							
a. The program has a process in place to review and improve accuracy of data entry & collection	☒	☐	☐	☐	☐	Netmis and JJIS data quality checks are conducted monthly by the data specialist and	

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Quality Improvement Indicators	Rating: Satisfactory	Rating – Explain: Non-compliant	Rating – Explain: No Eligible Items for Review	Rating – Explain: No Practice	Rating – Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						upon receipt of the data reports from the Florida Network.	
b. There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	☒	☐	☐	☐	☐	Regular meetings are held with committees, directors, and staff both independently and together to review data collected in order to review trends and identify areas needing improvements resulting from the analysis of data collected.	
c. There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	☒	☐	☐	☐	☐	The agency has a designated QI manager who coordinates these program improvement activities and monitor's progress. Documentation of agendas and meeting minutes are maintained.	
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) Policy and procedure #1.06 was last reviewed on July 1, 2018 and approved by the CEO.	
Approved agency drivers							
a. Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	☒	☐	☐	☐	☐	The program has two 12-person passenger vans (a red and a green 2015 Chevrolet) and maintains a list of 30 staff approved as drivers with valid Florida Driver's licenses.	
b. Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	☒	☐	☐	☐	☐	All staff listed as drivers are covered under the agency's insurance policy. Also, all third-party participants must be approved.	
Third party present in the vehicle							
a. Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd	☒	☐	☐	☐	☐	The agency's policy #1.06 prohibits transporting a client without maintaining at least one other passenger in the vehicle during the trip and includes exceptions when a 3rd party cannot be present.	

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Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
party is NOT present in the vehicle while transporting							
b. In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	☐	☒	☐	☐	☐	Six months of transportation logs reviewed indicated six individual one to one transport. A single transport on July 3, 2020 did not provide documentation of supervisor's approval.	**Exception:** No documentation of supervisor's approval or consideration of the client's history was on file for a single transport on July 3, 2020.
c. The 3rd party an approved volunteer, intern, agency staff, or other youth	☒	☐	☐	☐	☐	Transportation logs for the past 6 months showed third party included agency staff, or other youth.	
Transportation documentation							
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location	☒	☐	☐	☐	☐	Reviewer reviewed the agency's transportation logbooks that record each time a youth is transported. The log entries include name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	
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) Policy and procedure #1.07 was approved on 7/1/18 by the CEO.	
a. The program has a lead staff member designated to participate in local DJJ board and council meetings with evidence that includes minutes of the event or other verification of staff participation	☒	☐	☐	☐	☐	The Program participates in local DJJ Board and Council Meetings to ensure CINS/FINS services are represented. The organization's Chief Program Officer is the designated lead to participate in the meetings. Minutes of meetings attended March 13th and June 12th documented agency representative was present.	
b. Outreach and prevention services are provided by designated staff and include increasing	☒	☐	☐	☐	☐	Miami Bridge offered around 35 informational and educational outreach services during the	

Quality Improvement Review

Miami Bridge Homestead– November 4-5, 2020
Lead Reviewer: Marcia Tavares

Quality Improvement Indicators	Rating: Satisfactory	Rating: Explain: Non-compliant	Rating: Explain: No Eligible Items for Review	Rating: Explain: No Practice	Rating: Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
community awareness, offering informational and educational CINS/FINS services to youth and families.						past 6 months. Outreach activities are entered into NetMIS and a printout of activities was reviewed.	
c. The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	☒	☐	☐	☐	☐	Agency maintains a list of 38 inter-agency agreements including services for education, mental health, legal, medical, LGBTQ, vocational, and homelessness. All written agreements reviewed are active and/or ongoing.	
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 was approved on 7/1/18 by the CEO.	
Eligibility screening is completed within 7- calendar days of referral	☒	☐	☐	☐	☐	For indicators 2.01-2.05, a total of 5 residential files (3 closed, 2 open) and 5 non-residential files (3 closed, 2 open) were reviewed. All 5 residential files and 5 non-residential files contained screenings that were completed within 7 calendar days of the referral and were completed upon admission to the program.	
Youth and parents/guardians receive the following in writing: • Available service options • Rights and responsibilities of youth and parents/guardians	☒	☐	☐	☐	☐	All 10 files contained signed documents stating parents/guardians receive the resident/client handbook as well as information regarding available service options, and rights and responsibilities of the youth and parent/guardian.	
The following is also available to the youth and parents/guardians:	☒	☐	☐	☐	☐	All 10 files contained signed documents stating that parents and guardians receive the CINS/FINS brochure which includes grievance	

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Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
• Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) • Grievance procedures						procedures and information for parents and youth about possible actions occurring through involvement with CINS/FINS.	
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 was approved on 07/01/18 and signed by the CEO.	
Completion of Needs Assessment							
a. Shelter Youth: Needs Assessment initiated within 72 hours of admission	☒	☐	☐	☐	☐	Five residential youth records were reviewed. The Needs Assessment was initiated within 72 hours in 4 of 5 records. The case notes provided an explanation for Needs Assessment was not being initiated within 72 hours in 1 of 5 youth records reviewed because the youth came in on a Saturday and had several runaway episodes, delaying the initiation of the Needs Assessment.	
b. Non-Residential youth: Needs Assessment is done within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	☒	☐	☐	☐	☐	Five non-residential youth records were reviewed. The Needs Assessment was completed within 2 to 3 face-to-face contacts in all 5 records.	
c. Needs Assessment is conducted by a bachelor's or master's level staff member	☒	☐	☐	☐	☐	All ten Needs Assessments were conducted by a Bachelor's or Master's level staff member.	
d. Needs Assessment includes a supervisor's review signature upon completion	☒	☐	☐	☐	☐	A supervisor's signature was present on all 10 Needs Assessments reviewed.	
Suicide Risk as a Result of the Needs Assessment							
a. Youth was identified with an elevated risk of suicide as a result of the Needs Assessment	☒	☐	☐	☐	☐	Applicable to 1 of the 5 residential youth records. The youth was referred by a Baker Act	

Miami Bridge Homestead– November 4-5, 2020
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Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						facility and consequently identified with an elevated risk of suicide.	
b. If yes, the youth was referred for an Assessment of Suicide Risk conducted by or under the direct supervision of a licensed mental health professional	☒	☐	☐	☐	☐	Proof of a completed Assessment of Suicide Risk, conducted by a licensed professional, was observed in the youth record.	
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 procedure #2.03 was approved on 07/01/18 and signed by the CEO.	
Case/Service plan is developed within 7 working days of Needs Assessment	☐	☒	☐	☐	☐	Verified in 9 of 10 records reviewed.	**Exception** The service plan was not developed within 7 working days of completion of the needs assessment in 1 (residential) of the 10 records reviewed.
Case/Service Plan includes:							
• Individualized and prioritized need(s) and goal(s) identified by the Needs Assessment • Service type, frequency, location • Person(s) responsible • Target date(s) for completion and Actual completion date(s) • Signature of youth, parent/guardian, counselor, and supervisor • Date the plan was initiated	☒	☐	☐	☐	☐	The case plans in all 10 files reviewed was observed to include all elements required by the indicator. Youth signatures were not present in 7 of the 10 files and parent/guardian signatures were missing in 9 of 10 files; however, the case notes clearly states that they were present remotely due to COVID-19 but were not physically present to sign the service plans.	
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	☒	☐	☐	☐	☐	Applicable to and verified in 5 non-residential files and 4 residential files reviewed.	
2.04: Case Management and Service Delivery							

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Quality Improvement Indicators	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
	Rating	**Explain**					
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						☒ YES ☐ NO (explain) Policy and procedures #2.04 was approved on 07/01/18 and signed by the CEO.	
Counselor/Case Manager is assigned	☒	☐	☐	☐	☐	Each of the 10 records reviewed showed a counselor was assigned to the youth.	
The Counselor/Case Manager completes the following as applicable: • Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs • Coordinates service plan implementation • Monitors youth's/family's progress in services • Provides support for families • Monitors out-of-home placement (if necessary) • Makes referrals to the case staffing to address problems and needs of the youth/family • Accompanies youth and parent/guardian to court hearings and related appointments • Refers the youth/family for additional services when appropriate • Provides case monitoring and reviews court orders • Provides case termination notes • Provides follow-up after 30 days of exit • Provides follow-up after 60 days of exit	☒	☐	☐	☐	☐	All 10 records reviewed demonstrated applicable case management services were provided as needed and progress is monitored. Referral, service plan implementation, monitoring of progress, and family support was observed in all 10 records. Follow-ups after 30 and 60 days of exit was observed in 6 closed records reviewed.	
2.05: Counseling Services							

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	Rating	Explain					
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						☒ YES ☐ NO (explain) Policy and procedure #2.05 was approved on 11/05/2019 and signed by the CEO.	
Youth and families receive counseling services, in accordance with the youth's case/service plan, to address needs identified during the assessment process	☒	☐	☐	☐	☐	Service plans and case notes maintained demonstrated all 10 youth received individual counseling services as identified during the assessment.	
Shelter Program							
Shelter programs provides individual and family counseling	☒	☐	☐	☐	☐	Applicable to 5 residential records reviewed. All 5 demonstrated individual and/or family counseling was offered.	
Group counseling sessions held a minimum of five days per week	☐	☒	☐	☐	☐	The program reports providing group sessions daily; however, some group sessions are poorly documented and/or does not meet the criteria for groups.	**Exception** The program was not able to demonstrate group sessions are held five times per week consistently during the review period.
Group counseling sessions consist of: • Length of at least 30 minutes • Opportunity for youth engagement • Clear and relevant topic (informational/developmental/educational) • Clear leader or facilitator	☐	☒	☐	☐	☐	Review of group schedule and group log for April – September 2020.	**Exception** Several group notes did not have the date, time, and activity documented for group sessions. Two youth records reviewed were present during groups but the group notes do not reflect the time or topic.
Non-residential Program							
Non-residential programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, or the local provider's counseling office.	☒	☐	☐	☐	☐	Verified in all five non-residential records reviewed. Community based services were provided to keep families intact and minimize out of home placement.	
Counseling Services							
Reflect all case files for coordination between presenting problem(s), psychosocial assessment,	☒	☐	☐	☐	☐	Coordination of services was observed in all 10 files reviewed.	

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Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
case/service plan, case/service plan reviews, case management, and follow-up							
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	☒	☐	☐	☐	☐	All youth records are entered and maintained electronically in the Lauris Online system. An individual youth record is on file for all 10 youth files reviewed.	
Case notes maintained for all counseling services provided and documents youth's progress	☒	☐	☐	☐	☐	Legible case notes are maintained in Lauris online and individual records are validated for each youth.	
On-going internal process that ensures clinical reviews of case records and staff performance	☒	☐	☐	☐	☐	All 10 records reviewed were signed by the supervisor and/or licensed professional.	
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 was approved on 07/01/18 and signed by the CEO.	
Case Staffing Initiation and Notifications							
If parent/guardian initiates, staffing is held within 7 days	☒	☐	☐	☐	☐	Two applicable case staffing youth records were reviewed for the QI period. The case staffing was requested by staff in the two records.	
The youth, family and case staffing committee are contacted within a minimum of five working days • Notification to youth/family no less than 5 working days prior to staffing • Notification to committee no less than 5 working days prior to staffing	☐	☒	☐	☐	☐	Two case staffing records were reviewed.	**Exception** Case staffing notification to youth/family and committee was less than 5 days for 2 cases reviewed.
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	☒	☐	☐	☐	☐	Documentation in the 2 youth records reviewed showed a representative from the local school district and DJJ representative/CINS-FINS provider were members of the case staffing.	

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Quality Improvement Indicators	Rating					Review Based Upon	Notes
		Explain					
	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	**Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Other members may include: • State Attorney's Office • Others requested by youth/family • Substance abuse representative • Law enforcement representative • DCF representative • Mental health representative	☒	☐	☐	☐	☐	One of the 2 case staffings held included a Substance Abuse representative.	
The program has an established case staffing committee, and has regular communication with committee members	☒	☐	☐	☐	☐	Members of the case staffing committee include representatives from: school district, DJJ, and program staff.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	☒	☐	☐	☐	☐	Outlined in policy 2.06	
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services	☒	☐	☐	☐	☐	Reviewed service plans for two applicable youth.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	☒	☐	☐	☐	☐	The parent/guardian is provided a report of the committee recommendations at the end of the case staffing meeting.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	☐	☐	☒	☐	☐	Neither of the two youth records reviewed needed judicial intervention for the youth/family.	
Case Manager/Counselor completes a review summary prior to the court hearing	☐	☐	☒	☐	☐	No court intervention was required for the two records reviewed.	
2.07: Youth Records							
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						☒ YES ☐ NO (explain) Policy and procedure #2.07 was approved on 07/01/18 and signed by the CEO.	

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All records are marked "confidential	☒	☐	☐	☐	☐	All youth records are documented in the agency's EMR "Lauris online" system. Staff interviewed stated 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.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	☒	☐	☐	☐	☐	Former hard copy files are kept on-site in the secured, non- residential FSFF office building. The file cabinet is locked and marked "Confidential".	
When in transport, all records are locked in an opaque container marked "confidential"	☒	☐	☐	☐	☐	When the youth records are transported offsite, they are stored in an opaque, secured, box with a lock.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	☒	☐	☐	☐	☐	All ten files reviewed were observed to be organized and electronically maintained in a neat order.	
2.08: Sexual Orientation, Gender Identity, Gender Expression							
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						☒ YES ☐ NO (explain) Policy and procedure #2.08 was approved on 07/01/2018 and signed CEO.	
Use of youth's preferred name/pronoun: a. Youth are addressed according to their preferred name and gender pronouns b. Youth's preferred name and gender pronouns are used in logbook and on all outward-facing documents and census boards	☐	☐	☒	☐	☐	Since the last QI visit the program has not served any youth who meets the criteria for this indicator. However, policies and procedures are established to meet the requirements.	
Youth in need of specialized support is referred to qualified resources (as applicable)	☐	☐	☒	☐	☐	N/A	
Youth preference is considered and documented for room assignment and youth is not roomed in isolation	☐	☐	☒	☐	☐	N/A	

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Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
due to sexual orientation, gender identity, or gender expression							
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression	☐	☐	☒	☐	☐	N/A	
The agency has signage and brochures/publication placed in common areas indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression	☒	☐	☐	☐	☐	During tour of the facility, safe zone rainbow stickers were posted throughout 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 on the entry window, two on intake office window, on a poster board in each dorm, posted on boards in the dorm hallways, on the counselors' and administrative office doors/windows, and throughout the First Stop Non-residential office building. 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 has documentation to support all 3 new staff were trained and are familiar with Florida Network policy #5.08.	
2.09: Special Populations							
Provider has a written policy and procedure that meets the requirement for Indicator 2.09 for EACH special population served i.e. Staff Secure, DMST,DV, PR, ICM and FYRAC.						☒ YES ☐ NO (explain) Policy and procedure #3.07 was last updated on 7/1/18 and signed by the CEO	

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		Explain					
	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Staff Secure							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	☐Yes ☒ No			☐N/A		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.	
Staff Secure policy and procedure outlines the following: • In-depth orientation on admission • Assessment and service planning • Enhanced supervision and security with emphasis on control and appropriate level of physical intervention • Parental involvement • Collaborative aftercare	☒	☐	☐	☐	☐	Policy 3.07	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	☐	☐	☒	☐	☐	No applicable youth files to review.	
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	☐	☐	☒	☐	☐	No applicable youth files to review.	
Agency provides a written report for any court proceedings regarding the youth's progress	☐	☐	☒	☐	☐	No applicable youth files to review.	
Domestic Minor Sex Trafficking (DMST)							

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Quality Improvement Indicators	Rating: Satisfactory	Rating: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	☐Yes ☒ No			☐N/A			
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements	☐	☐	☒	☐	☐	No applicable youth files to review.	
Services provided to these youth specifically designated services designed to serve DMST youth	☐	☐	☒	☐	☐	No applicable youth files to review.	
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	☐	☐	☒	☐	☐	No applicable youth files to review.	
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	☐	☐	☒	☐	☐	No applicable youth files to review.	
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	☐	☐	☒	☐	☐	No applicable youth files to review.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	☐	☐	☒	☐	☐	No applicable youth files to review.	
Domestic Violence							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	☒Yes ☐ No			☐N/A			

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Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Youth admitted to DV Respite placement have a pending DV charge and have evidence of being screened by JAC/Detention, but do not meet criteria for secure detention	☒	☐	☐	☐	☐	Three closed DV youth records were reviewed. A DJJ Face sheet was present in all 3 files showing JAC screening and pending DV charge for each youth	
Data entry into NetMIS and JJIS within 24 hours of admission and 72 hours of release	☒	☐	☐	☐	☐	NetMIS youth listings report and JJIS discharge data entry log for each youth showed data was entered timely for all 3 youth.	
Youth in program do not have length of stay in DV Respite placement that exceeds 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	☒	☐	☐	☐	☐	One of the DV youth exceeded 21 days at the shelter program. Documentation supported youth was transitioned to CINS/FINS on the 21st day with supporting documentation.	
Case plan in file reflects goals focusing aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home	☒	☐	☐	☐	☐	Case plans in three youth records reflect goals for reducing violence and coping skills.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	☒	☐	☐	☐	☐	Case notes demonstrate all three youth received shelter services consistent with CINS/FINS program requirements.	
Probation Respite							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	☐Yes ☒ No			☐N/A			
Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status	☐	☐	☒	☐	☐	No applicable youth files to review.	
Data entry into NetMIS and JJIS within 24 hours of admission and 72 hours of release	☐	☐	☒	☐	☐	No applicable youth files to review.	
Length of stay is no more than fourteen (14) to thirty (30) days? (Placement beyond thirty (30) days requires the approval of the JPO and/or CPO)	☐	☐	☒	☐	☐	No applicable youth files to review.	
All case management and counseling needs have been considered and addressed	☐	☐	☒	☐	☐	No applicable youth files to review.	

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Quality Improvement Indicators	Rating: Satisfactory	Rating (Explain): Non-compliant	Rating (Explain): No Eligible Items for Review	Rating (Explain): No Practice	Rating (Explain): Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	☐	☐	☒	☐	☐	No applicable youth files to review.	
Intensive Case Management (ICM)							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	☐Yes ☐ No			☒N/A		Miami Bridge is not contracted to provide ICM services.	
Youth receiving services was court ordered or referred by case staffing committee	☐	☐	☐	☐	☒	N/A.	
Services for youth and family include: a. Six (6) direct contacts per month b. Six (6) collateral contacts per month	☐	☐	☐	☐	☒	N/A.	
Assessments include: a. A Child Behavior Checklist (CBCL) is completed within 14 days of intake and at discharge (if applicable) b. An approved self-report assessment that was completed at intake c. An approved self-report assessment that was completed every 90 days following intake and at discharge (if applicable)	☐	☐	☐	☐	☒	N/A.	
Case plan demonstrates a strength-based, trauma-informed focus	☐	☐	☐	☐	☒	N/A.	
Agency has evidence that ICMS has a strength-based perspective in one or more of the following areas; engaging the family, advocating on their behalf, initiating change agent activities, helping to access supports in the community, teaching problem solving skills, modeling productive behaviors, and/or successful completion of youth and family developmental milestones	☐	☐	☐	☐	☒	N/A.	

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Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Family and Youth Respite Aftercare Services (FYRAC)– Non-residential Only							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	☐Yes ☒ No			☐N/A			
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating	☐	☐	☒	☐	☐	No applicable youth files to review.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	☐	☐	☒	☐	☐	No applicable youth files to review.	
Intake and initial assessment sessions meets the following criteria: a. Face-to-face gathering of family history and demographic information b. Includes development of the service plan and is documented through signature of the youth and his/her parent/guardian as well as orientation to the program	☐	☐	☒	☐	☐	No applicable youth files to review.	
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Individual Sessions are with the youth and family and focus to engage, identify strengths and needs of each member that help to improve family functioning	☐	☐	☒	☐	☐	No applicable youth files to review.	
Group Sessions: a. Focus on the same issues as individual/family sessions with the overall goal of strengthening relationships and prevention domestic violence	☐	☐	☒	☐	☐	No applicable youth files to review.	

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b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session							
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	☐	☐	☒	☐	☐	No applicable youth files to review.	
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 Miami Bridge Homestead is not contracted to provide SNAP services.	Miami Bridge is not a SNAP provider.
SNAP Clinical Groups							
Youth are screened to determine eligibility of services	☐	☐	☐	☐	☒	N/A.	
Needs assessment is completed at initial intake, or within two face-to-face sessions	☐	☐	☐	☐	☒	N/A.	
SNAP Assessments a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post)	☐	☐	☐	☐	☒	N/A.	
b. Teacher Report Form (TRF) completed by the teacher (pre & post)	☐	☐	☐	☐	☒	N/A.	
c. TOPSE (pre & post)	☐	☐	☐	☐	☒	N/A.	
d. Prevention Assessment Tool (PAT) (pre & post)	☐	☐	☐	☐	☒	N/A.	
SNAP® discharge report summary	☐	☐	☐	☐	☒	N/A.	

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SNAP® Boys/SNAP® Girls Child Group Evaluation Form	☐	☐	☐	☐	☒	N/A.	
SNAP® Boys/SNAP® Girls Parent Group Evaluation Form	☐	☐	☐	☐	☒	N/A.	
SNAP in Schools							
Weekly attendance sheet with youth names and/or identifying number completed with signatures of teacher and facilitator(s) (For a total of 13 attendance sheets)	☐	☐	☐	☐	☒	N/A.	
"Class Shoot for Your Goal" sheet	☐	☐	☐	☐	☒	N/A.	
Pre and Post Evaluations	☐	☐	☐	☐	☒	N/A.	
One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox	☐	☐	☐	☐	☒	N/A.	
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) Policy and procedure #3.01 was approved on 7/1/18 and signed by the CEO.	
Facility Inspection	☒	☐	☐	☐	☐	A tour of the shelter facility was completed during which the program was observed to be clean, neat, and pleasant smelling. The program has a full-time maintenance staff person on-site to complete routine	

Quality Improvement Indicators	Rating: Satisfactory	Rating: Non-compliant (Explain)	Rating: No Eligible Items for Review (Explain)	Rating: No Practice (Explain)	Rating: Not Applicable (Explain)	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						maintenance and needed repairs. A noticeable crack in the concrete pavement on the walkway was observed. Per the Chief Business Officer, pending repairs have been documented and indicated on the CDBG Bid notices awaiting approval. The shelter has adequate space for scheduled daily activities and youth sleeping areas. Each dorm room is furnished with 10 beds (2 per bunk bed), individual lockers for youth, TV, and a gaming system. Due to COVID-19, Homestead now only admits male youth so that one of the dormitories can be used for quarantine. The facility maintains a clean and organized laundry room with two operational clothes washers and two operational dryers which had clean lint collectors. All observed furniture is in good repair. Seating was adjusted in the day room to accommodate social distancing. Each youth is provided an assigned bed with new Tuft and Needle memory foam mattresses, a pillow, attractive bed linens and comforter. All bathrooms were observed to be clean and functional. No graffiti was observed and there was no evidence of insect infestation. Chemicals approved for use were listed and maintained in the kitchen storage closet under three locks. Observed garbage cans and the dumpster were all covered. The facility has detailed egress plan maps posted throughout facility. Detailed egress maps were posted in each room of the shelter indicating facility exit	

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Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						paths. Additional postings included client rules, grievance forms, Florida Abuse Hotline information, and the Department's Central Communications Center incident reporting number. The annual food hygiene sanitation inspection was completed, and the certificate was issued on October 1, 2020 with no restrictions. A satisfactory county Health Department food inspection was completed 2/4/2020 and group care inspection was completed 10/19/2020; there are no outstanding violations resulting from the inspections. The current active CCA-Emergency Active license was issued on March 1, 2020 for 20 beds, is valid through February 28, 2021 and was posted in the program's common area.	
Fire and Safety Health Hazards	☐	☒	☐	☐	☐	Miami Dade Fire Prevention Division conducted a satisfactory Annual Fire Inspection on 8/27/20 for buildings A (shelter), B (FSFF) and Building C (School site); no violations were noted for A & B. Valid Fire permits are in place for building A and building B through 4/30/21. Building C inspection resulted in violations requiring change and certificate of occupancy for the school site to be designated as a school. Per the Chief Business Officer, after 20 plus years the fire department has now requested for the first year a special certificate of occupancy that designates that building use is specifically for "school use". He is working with the building	**Exception** A review of mock emergency drills revealed no mock emergency drills were completed on the overnight shift for the past 6 months and the last drill for the 1st shift was July 2020.

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Quality Improvement Indicators	Rating					Review Based Upon	Notes
		Explain					
	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						department to determine if one ever existed or how it can be obtained for the first time. The program is required to conduct a minimum of one fire drill per month with evacuation in two minutes or less. Drills are completed once per shift per month. Seven of the 18 drills exceeded 2 minutes per the drill report forms; however, based on the comments of the drill forms, It appears 6 of the 7 drills were capturing total drill time instead of evacuation times. Only of the drills did not indicate evacuation time separate from total time. A review of episodic emergency drills revealed no mock emergency drills were completed on the overnight shift for the past 6 months and last drill for the 1st shift was July 2020. Documentation reviewed indicated the fire extinguishers were recently inspected and are valid through October 2021. The program has 2 refrigerators and 2 freezers in the kitchen. Inspection of the refrigeration equipment demonstrated refrigerators and freezers are operational and optimal temperatures are maintained.	
Youth Engagement							
• Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal.	☒	☐	☐	☐	☐	The program's weekly activity schedule is posted in each dormitory and in the day room. The program's schedule engages youth in meaningful, structured activities seven days a week during waking hours. Youth are provided the opportunity to participate in weekly faith-	

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
• At least one hour of physical activity is provided daily. • Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. • Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. • Daily programming schedule is publicly posted and accessible to both staff and youth.						based activities. The daily schedule includes at least one hour of physical activity/recreation. Activities include outdoor large muscle activity and exercise, playing pool, or various field trips, including equine therapy. Idle time is minimal.	
3.02: Program Orientation							
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						☒ YES ☐ NO (explain) Policy and procedure #3.02 was approved on 7/1/18 and signed by the CEO.	
Youth received a comprehensive orientation and handbook provided within 24 hours	☒	☐	☐	☐	☐	The review of three active and one closed youth record indicated each youth received a program orientation and a copy of the program handbook within the first twenty-four hours after each youth's admission to the program.	
Orientation includes the following							
a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure	☒	☐	☐	☐	☐	The 4 youth orientation checklists reviewed included all the items required by the indicator.	

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Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts							
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	☒	☐	☐	☐	☐	Components of the orientation is documented on an orientation checklist that is acknowledged by the youth's dated signature as well as that of a staff. The program maintains a professional-looking printed youth and guardian handbook and orientation guide for emergency shelter services.	
3.03: Youth Room Assignment							
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						☒ YES ☐ NO (explain) Policy and procedure #3.03 was approved on 7/1/18 and signed by the CEO.	
A process is in place that includes an initial classification of the youths, to include:							
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior	☒	☐	☐	☐	☐	A review of four youth records validated each youth completed an initial classification that includes all of the items required by the indicator and is documented on page 2 of the CINS/FINS intake assessment form.	
An alert is immediately entered into the program's alert system when a youth is admitted with special	☒	☐	☐	☐	☐	The agency's alert system includes precautions concerning the prescribed	

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors						medications, medical/mental health conditions, and allergies are documented in several locations throughout the client's medical file and electronic medical record. An alert board located in the intake office also documents the client's name and alert in a confidential manner. A nutritional alert clipboard is in the kitchen which includes a list client's who have an allergy or other kind of nutritional alert.	
3.04: Log Books							
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						☒ YES ☐ NO (explain) Policy and procedure #3.04 was approved on 7/1/18 and signed by the CEO.	
Log book entries that could impact the security and safety of the youth and/or program are highlighted	☒	☐	☐	☐	☐	The program utilizes the Note Active electronic logbook as it's system of record for daily activities. The appropriate active notes on the platform are used to highlight safety and security issues as necessary. Randomly selected one-week samples of the program logbook for each month during the past six months were reviewed. Dates reviewed are as follows: 1st April to 7th April; 8th May to 14th May; 15th June to 21st June; 22nd July to 31st July; 1st August to 7th August; and 8th September to 14th September 2020.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	☒	☐	☐	☐	☐	The E logbook makes all of the entries legible. Program entries are brief and information based. Use of the e logbook afford the program the ability to have all entries date and time stamped. Additionally, all program staff have	

Quality Improvement Indicators	Rating: Satisfactory	Rating/Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						individual login information for identification of the entries.	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	☒	☐	☐	☐	☐	The E logbook has a strike through feature which the program has utilized when appropriate.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	☐	☒	☐	☐	☐	Reviews of the program's logbook for the past year was conducted to establish supervisory reviews are conducted every week.	**Limited Exception** The program's policy and procedures require supervisory reviews of logbooks weekly; however, the electronic logbook indicated supervisory reviews occurred only eight times since December 4, 2019. Supervisory reviews were documented on December 4, 2019, January 28, March 3, May 15, May 27, August 21, September 11, and October 31. Additionally, six of the eight supervisory reviews did not notate whether any deficiencies were observed.
Supervisors and all staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	☒	☐	☐	☐	☐	During the review period, there was clear evidence of staff reviewing the logbook at the beginning of each shift and documenting accordingly.	
Logbook entries include: • Supervision and resident counts • Visitation and home visits	☒	☐	☐	☐	☐	Resident counts are documented throughout the day. The active notes on the digital platform is utilized to show counts. All program activities and movement including visitation and home visits are documented daily.	
3.05: Behavior Management Strategies							
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						☒ YES ☐ NO (explain) Policy and procedure #3.05 was approved on 7/1/18 and signed by the CEO.	
The program has a detailed written description of the BMS, and it is explained during program orientation	☒	☐	☐	☐	☐	The behavior management description is clearly identified in the consumer handbook,	

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						posted throughout the program, and is given to youth at intake.	
Behavior Management Strategies must include:							
a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	☒	☐	☐	☐	☐	Reviewed documentation that confirmed the program has a behavior management system (BMS) designed to encourage compliance with the program rules, influence positive behavior, and increase accountability using incentives and rewards to encourage participation and completion of the program. The program uses a point system to manage behaviors. The system provides youth with an opportunity to earn points for complying with program expectations or to lose points for infractions. The system consists of four levels with an increase in privileges as you advance through the levels. Loss of points is broken down into three tiers with a range of 50-150 points. Staff are trained to exhaust all strategies to appropriately managing behavior prior to taking points. The program has an incentive program as part of the behavior management system. Program staff take an inventory of trendy items that youth like and purchase to offer as incentives. The program holds "feel good Friday" on a weekly basis to provide youth an opportunity to be recognized for their achievements and to earn incentives. Youth are made aware of consequences for violation of program expectations during orientation. Additionally, program expectations and consequences are posted throughout the facility. When the youth face consequences for major infractions, counselors are present to	

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		Explain					
	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						support youth in processing the connection between their actions and the consequence.	
Program's use of the BMS							
All staff are trained in the theory and practice of administering BMS rewards and consequences	☒	☐	☐	☐	☐	All staff receive training on the BMS system. Training is provided by one of the program's counselors and certificates of completion are maintained in employee training files.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	☒	☐	☐	☐	☐	Program supervisor monitors point cards to evaluate and provide feedback to staff during staff meetings on use of behavior management system and on youth engagement.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	☒	☐	☐	☐	☐	Supervisors receive training in the monitoring of the BMS. Program supervisor provides oversight to ensure the behavioral interventions are being used appropriately.	
3.06: Staffing and Youth Supervision							
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						☒ YES ☐ NO (explain) Policy and procedure #3.06 was approved on 7/1/18 and signed by the CEO.	
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	☒	☐	☐	☐	☐	A review of the program schedules for the previous six months revealed the program maintained a minimum staffing ratio of 1:6 during wake hours and 1:12 during sleep period.	
Overnight shifts must always provide a minimum of two staff present	☒	☐	☐	☐	☐	During the current review period, the program maintained a minimum of two staff consistently. Adjustments to the supervision plan were made to support the needs of the program during the pandemic. The program utilized staff to support and supervise youth in quarantine.	

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The staff schedule is provided to staff or posted in a place visible to staff	☒	☐	☐	☐	☐	During the tour of the facility, the staff schedule was posted in the intake office as well as the program manager's office.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	☒	☐	☐	☐	☐	A holdover roster is maintained by the program director and is used to solidify additional coverage as needed.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	☐	☒	☐	☐	☐	An informal interview with program staff indicated the clocks for the video surveillance system and the electronic logbook are not synced together, therefore, the time indicated on the electronic logbook differs from the time stamp shown on the video footage. It is the program's practice for staff to first observe youth in their sleeping room and then log the check in the electronic logbook after the check is completed. Additionally, the program's policy and procedures require staff to be positioned immediately outside of the dormitories within view of the video cameras; however, the program has instituted alternative measures during the pandemic to minimize exposure by not stationing themselves in the immediate vicinity of the dormitories. A review of bed checks within the past 30 days revealed inconsistencies in completing checks every 15 minutes.	**Failed Exception** A review was conducted of provided video surveillance footage clips recorded between 12:00 a.m. and 4:00 a.m. on October 10, October 14, October 18 and October 30 which revealed bed checks were not consistently conducted at least every fifteen minutes while youth were in their sleeping room. • The logbook for October 10, 2020 reported twelve bed checks were conducted on each sleeping room between 12:00 a.m. and 4:00 a.m. • The video review of October 10, 2020 revealed staff entered the first sleeping room (the door to which is in view of camera #8) thirteen times during that time period, seven of which were more than fifteen minutes since the last entrance, ranging from 22 to 37 minutes between checks. • The video review of October 10, 2020 revealed staff entered the second sleeping room (the door to which is in view of camera #9) ten checks were conducted during that time period, seven of which were more than fifteen minutes

Quality Improvement Indicators	Rating					Review Based Upon	Notes
		Explain					
	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	**Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
							since the last entrance, ranging from 22 to 37 minutes between checks. • The logbook for October 14, 2020 reported seventeen bed checks were conducted of each sleeping room between 12:00 a.m. and 4:00 a.m. • The video review of October 14, 2020 revealed staff entered the first sleeping room sixteen times during that time period, one of which was 18 minutes since the last entrance. • The video review of October 14, 2020 revealed staff entered the second sleeping room sixteen times during that time period, five of which were more than fifteen minutes since the last entrance, ranging from 16 to 18 minutes. • The logbook for October 18, 2020 reported sixteen bed checks were conducted of each sleeping room between 12:00 a.m. and 4:00 a.m. • The video review of October 18, 2020 revealed staff entered the first sleeping room seventeen times during that time period, three of which were more than fifteen minutes since the last entrance, ranging from 16 to 27 minutes. • The video review of October 18, 2020 revealed staff entered the second sleeping room sixteen times during that time period, two of which were more than fifteen minutes since the last entrance, ranging from 17 to 32 minutes. • The logbook for October 30, 2020 reported fifteen bed checks were

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							conducted of each sleeping room between 12:00 a.m. and 4:00 a.m. • The video review of October 30, 2020 revealed staff entered the first sleeping room fifteen times during that time period, eight of which were more than fifteen minutes since the last entrance, ranging from 16 to 19 minutes. • There were no videos provided for October 30, 2020 of the entrance to the second sleeping room and it was assumed there were no youth sleeping in that room on that night. CCC was contacted regarding discrepancy in number of logbook entries documented on 10/14 and 10/18 versus the number observed on camera. Report was accepted CCC# 202007065. The program received a Limited rating for this indicator during the last QI review and failed to demonstrate proficiency during this subsequent review. Due to the critical nature of this indicator with regards to youth supervision and safety, this indicator is rated as Failed.
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 was approved on 7/1/18 and signed by the CEO.	
Surveillance System							

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Quality Improvement Indicators	Rating	Explain				Review Based Upon	Notes
	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	**Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	☒	☐	☐	☐	☐	A review of the program's surveillance system was conducted during the facility tour. The program maintains a digital surveillance video system with thirty-two cameras, fifteen on the interior and seventeen on the exterior of the building. The video system was observed to operational with images in which faces are easily identifiable. As the program does not maintain security cameras in either dormitory, it is the program's practice for staff to approach the entrance of the dormitories within sight of the security camera at least once every fifteen minutes.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	☒	☐	☐	☐	☐	Agency maintains a list of four agency staff authorized to have access to the cameras including the Chief Business Officer, the North and South shelter supervisors and the CQI Coordinator.	
Supervisory review of video is conducted a minimum of once every 14 days and noted in the logbook. The reviews assess the activities of the facility and include a review of random sample of overnight shifts	☐	☒	☐	☐	☐	In addition to reviewing entries in the e-logbook during the QI period, the shelter program manager was interviewed to ascertain practice of conducting supervisory video reviews.	**Limited Exception** The program's policy and procedures requires supervisory review at least once every fourteen days; however, the electronic logbook indicated supervisory review of logbooks and video occurred only eight times since December 4, 2019 as follows: December 4, January 28, March 3, May 15, may 27, August 21, September 11, and October 31. Additionally, six of the eight supervisory reviews did not notate whether any deficiencies were observed.

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Quality Improvement Indicators	Rating: Satisfactory	Rating (Explain): Non-compliant	Rating (Explain): No Eligible Items for Review	Rating (Explain): No Practice	Rating (Explain): Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	☒	☐	☐	☐	☐	Policy 3.07 indicates that third party review can be made available during investigations and in conjunction with specific incidents.	
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 was approved on 7/1/18 and signed by the CEO.	
Preliminary Healthcare Screening							
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc.; and g. Observation for presence of scars, tattoos, or other skin markings	☒	☐	☐	☐	☐	A total of four residential youth records were reviewed including two open and two closed files. Healthcare Admission Screening Forms were completed at the time of intake by direct care staff for all files reviewed and were completed in its entirety. All client files reviewed reflected that a review of Health Care Admissions Screening/Intakes were completed by the Nurse or designated staff.	
Referral and Follow-up							
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	☒	☐	☐	☐	☐	None of the client files reviewed needed medical follow up; however, interview with the program's RN reflected that medical follow up referrals are documented in the electronic medical record on the Medical Documentation form, staff communication binder, and client medical file which was also observed.	

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Quality Improvement Indicators	Rating: Satisfactory	Rating (Explain): Non-compliant	Rating (Explain): No Eligible Items for Review	Rating (Explain): No Practice	Rating (Explain): Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	☒	☐	☐	☐	☐	Four youth records were reviewed and none of the records indicated the parent/guardian needed to be involved in healthcare services while the youth was in the program.	
All medical referrals are documented on a daily log.	☒	☐	☐	☐	☐	Each record indicated all healthcare referrals are documented on a daily log maintained in the youth's record.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	☒	☐	☐	☐	☐	The agency's policy states the program will work with the youth's parent/guardian and the provider's medical consultant, if needed, to ensure the youth receives proper medical care and follow-up.	
4.02 Suicide Prevention **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 was approved on 7/1/18 and signed by the CEO.	
Suicide Risk Screening and Approval							
a. Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	☒	☐	☐	☐	☐	A total of four residential client files including three closed files and one open file were reviewed. All youth records included the Suicide Risk Screening on the CINS/FINS intake form. Suicide Risk Screening forms were completed in their entirety and signed by the supervisor.	.
b. The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	☒	☐	☐	☐	☐	The agency uses the Suicide Assessment tool approved by the Florida Network.	
Supervision of Youth with Suicide Risk							

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Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
a. Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	☒	☐	☐	☐	☐	Four youth records were reviewed. One was applicable for placement on constant sight and sound supervision and youth was placed on the appropriate level based on the suicide risk assessment.	
b. Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	☒	☐	☐	☐	☐	Observation logs documented youth was monitored every fifteen minutes while on constant supervision.	
c. Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement?	☒	☐	☐	☐	☐	The youth's supervision level was not changed to standard supervision until the youth received a follow up Suicide Risk Assessment by the licensed clinician.	
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 was approved on 7/1/18 and signed by the CEO.	
Medication Storage							
a. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Oral medications are stored separately from injectable epi-pen and topical medications c. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) d. Narcotics and controlled medications are stored in the Med-Station	☒	☐	☐	☐	☐	A total of three open residential youth records were reviewed. Program staff including the RN and direct care staff were interviewed. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is placed behind a locked door that is inaccessible to youth. Oral medications are stored in separate bins of the Med Station, apart from topical or injectables. A refrigerator was observed to be secured with a lock in the medication storage room; however,	

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						the program does not currently have any meds needing refrigeration. At the time of the review the program did not have any narcotic medications. Program practice indicates that narcotics and controlled medications are stored in the med station.	
Medication Distribution							
a. Agency maintains a minimum of 2 Super Users for the Med-Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse	☒	☐	☐	☐	☐	The agency has 2 superusers for the Med-Station and 13 staff authorized to distribute medication. A medication distribution log was maintained for each youth record reviewed and are kept in a medication log binder. The program uses the 5 Rights method, (right dose, right route, right med, right patient, and right time),one of four methods listed in the FNYFS Operations Manual and delivery of medication is consistent with FN medication management policy. The program does not accept youth currently prescribed injectable medications, except epi pens. The agency has documentation that non-licensed staff have received training in the use of Epi-pens provided by the program's RN during medication training provided during orientation.	
Medication Inventory							

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a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	☒	☐	☐	☐	☐	Trained staff complete an inventory every shift of all the controlled substances. For controlled substances, the perpetual running balance is indicated on the shift to shift count. This is completed by two staff members and is documented on the youth's Medication Distribution Log (MDL). Shift to shift count documentation was reviewed. All areas of shift to shift counts were verified. Over-the-counter medications that are accessed regularly are inventoried weekly on a perpetual log that is reviewed and signed by the RN. A perpetual inventory is maintained on the youth's MDL each time a medication is given. Syringes and sharps were observed to be secured in a locked storage cabinet. Syringes and sharps inventory documentation shows that these are counted weekly. There is also documentation of a weekly review completed by the RN.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	☒	☐	☐	☐	☐	The program RN or Healthcare Specialist conducts monthly reviews of medication management practice via knowledge portal reports from med station. The outcome of these reports is then discussed during director's meetings.	
Medication discrepancies are cleared after each shift.	☒	☐	☐	☐	☐	If there are discrepancies to be cleared the RN is informed and discrepancies are cleared after each shift.	
4.04: Medical/Mental Health Alert Process							

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Provider has a written policy and procedure that meets the requirement for Indicator 4.04						☒ YES ☐ NO (explain) Policy and procedure #4.04 was approved on 7/1/18 and signed by the CEO.	
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	☒	☐	☐	☐	☐	A total of four residential client files including, three closed and one open file. All client files reviewed did have a medical or mental health condition or food allergy. All files reviewed demonstrated that the youth were appropriately placed on the program's alert system as this was reflected on the Youth Alert System form. The youth receives an initial medical screening at intake by either the RN if on site, the Health Specialist, or other non-licensed program staff. The agency's practice reflects that the RN or designee reviews and sign off on the medical screening.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	☒	☐	☐	☐	☐	The agency's alert system includes precautions concerning the prescribed medications, medical/mental health conditions are documented in several locations throughout the client's medical file and electronic medical record. An alert board located in the intake office also documents the client's name and alert in a confidential manner. A nutritional alert clipboard is in the kitchen which includes a list client's who have an allergy or other kind of nutritional alert.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	☒	☐	☐	☐	☐	Interview with the program's RN demonstrated that staff are provided sufficient information/instructions to recognize/respond to the need for emergency medical/mental health problems which was observed in 7 staff training files reviewed.	

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A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	☒	☐	☐	☐	☐	The program's alert system is communicated in multiple ways and documented to ensure staff is aware of these alerts: logbook, alert board, and youth files.	
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 was approved on 7/1/18 and signed by the CEO.	
Off-site Emergency Services							
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	☒	☐	☐	☐	☐	The program documents off site emergency medical incidents on the Client Transported Offsite Due to Emergency Medical Attention log. One applicable offsite emergency record reviewed includes date/time of incident, summary of incident, parental notification, summary of notification to parent, date/time client transported back and by whom, medical follow up recommended via discharge instructions, and parental notification of follow up as well as a critique by supervisor. The incident report was reviewed and a call was placed into the CCC within the reporting time frame and included appropriate follow up to CCC in required time frames.	
All staff are trained on emergency medical procedures	☒	☐	☐	☐	☐	All staff are trained on emergency medical procedures through CPR/FIRST AID/AED training. All but one training file reviewed were found to have current CPR and First Aid training.	

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		Explain					
	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	☒	☐	☐	☐	☐	Knife for life and wire cutter were observed in the shelter intake office as well as are located in the school building, First Stop Counseling building, and in both vans.	
First aid kit/supplies are fully equipped and inventoried	☒	☐	☐	☐	☐	First Aid kits/supplies are inventoried weekly by the Health Care Specialist. They were observed to be located in the shelter intake office, kitchen school building, First Stop counseling building, and 2 agency vans.	