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

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Modified 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 2021-2022 at its program offices located at 2810 NW South River Drive, Miami (Central) and the Miami Bridge Homestead location (Homestead) is 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 1, 2021 through June 30, 2022.

The reviews were conducted by Keith Carr and Marcia Tavares, Lead Reviewers for Forefront LLC, and Peer Reviewers. Agency representatives from Miami Bridge present for both entrance interviews were: Marlene Erven, Interim Executive Director; Alicia Sherman, Director of Finance; Mary Behr, Chief Program Officer; David Sharfman, Chief Operating Officer; Lashonda Chavis, Director of Admissions; Tracy Scott, RN/Homestead Shelter Manager, and Citizen Jane, Central Shelter Manager. The last QI reviews for Miami Bridge were conducted November 2020 (Homestead) and December 2020 (Central), with subsequent re-reviews on June 8, 2021, due to failed QI indicators at both program locations.

In general, the Reviewer found that Miami Bridge is in compliance with specific contract requirements. **Miami Bridge received an overall compliance rating of 100% for achieving full compliance all 11 applicable indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions or recommendations made as a result of the monitoring visit.

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

2021-2022 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 05-25-2021-2022

Agency Name: Miami Bridge Youth and Family Services Inc.	**Monitor Name(s): Keith Carr and 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): May 25-26, 2022**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of 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 Chavis and Citizen Jane. Ms. Chavis participated in a QI review for fiscal year (FY) 2021-2022.	
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 2021-2022 was provided. The list included funders such as the Children's Trust, United Way, Department of Health and Human Services, Citrus Health Network, Florida Department of Agriculture, as well as corporate and foundation grants. The provider also maintains an extensive list of over 38 Memorandum of Understanding (MOU) agreements with community agencies who provide medical, mental health, social,	

Agency Name: Miami Bridge Youth and Family Services Inc.						Monitor Name(s): Keith Carr and 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): May 25-26, 2022	
	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)
						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 12/27/21-12/27/2022 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 12/27/21-12/27/2022 Workers Compensation insurance is provided through Ascendant Commercial Insurance Co. with limits of $500,000 each/ $500,000 aggregate, effective 12/27/21-12/27/2022	

Agency Name: Miami Bridge Youth and Family Services Inc.						Monitor Name(s): Keith Carr and 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): May 25-26, 2022	
	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)
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						The provider also has an Umbrella policy through Philadelphia Indemnity Insurance Company, for limits of coverage $1,000,000 each and aggregate, effective 12/27/21-12/27/2022 as well as Professional Liability insurance with limits of coverage $1,000,000/$3,000,000 each/aggregate, effective 12/27/21-12/27/2022. The Florida Network is listed as additional insured on the certificate of insurance.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	The provider noted on the Programmatic Updates 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 Policy and Procedure Manual for Financial, Procurement, and Contract Management, approved on May 15, 2022, by the Interim Executive Director, was received and reviewed. The procedures appear to follow general GAAP guidelines and include procedures for: Financial	

Agency Name: Miami Bridge Youth and Family Services Inc.						Monitor Name(s): Keith Carr and 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): May 25-26, 2022	
	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)
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						Planning and Reporting; Internal Control; General Accounting and Records; Cash and Investment Management; Income and Accounts Receivable; Expenses and Accounts Payable; Property, Plant, and Equipment; Travel and Transportation Expense; and Payroll Processing.	
b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	The Agency utilizes Quick Books Enterprise to manage its finances for the agency and maintains an expansive and detailed General Ledger (GL) in which the CINS/FINS Program (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. The GL for the CINS/FINS Program for the period July 1, 2021- May 20, 2022, was reviewed and is on file with the reviewer.	

Agency Name: Miami Bridge Youth and Family Services Inc.	Monitor Name(s): Keith Carr and 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): May 25-26, 2022

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)
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. The card holder maintains a card custody log 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. P-card 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	

Agency Name: Miami Bridge Youth and Family Services Inc.						Monitor Name(s): Keith Carr and 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): May 25-26, 2022	
	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)
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						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**	☐	☐	☒	☐	☐	Reconciliation Reports for the period November 2021 – April 2022 were reviewed. Based on a review of these documents, all 6 bank reconciliations were prepared within 6 weeks of the end of the preceding month. 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 Bookkeeper.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over	☐	☐	☐	☐	☒	The provider maintains a record of program inventory on the Asset	

Agency Name: Miami Bridge Youth and Family Services Inc.	Monitor Name(s): Keith Carr and 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): May 25-26, 2022

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)
$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**						Account. No new equipment using Florida Network funds was purchased since the last QI 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**	☐	☐	☒	☐	☐	Federal 941 payments are prepared, processed, and submitted timely semi-weekly through the authorized contracted reporting agent ADP. Payroll payments are processed electronically by ADP. Copies of the provider's 941s for the 4th quarter 2021 and 1st quarter of 2022 were reviewed. No balances due were reported.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget is investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Agency provided budget vs. actual report for the current fiscal year through April 30, 2022, showing a net loss balance. Financial reports are reviewed with the Board of Directors 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	☐	☐	☒	☐	☐	The most recent Financial Audit was completed by Verdeja, De Armas, and	

Agency Name: Miami Bridge Youth and Family Services Inc.						Monitor Name(s): Keith Carr and 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): May 25-26, 2022	
	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)
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**						Trujillo CPA, for June 30, 2021, and 2020 per letter dated December 20, 2021. The audit did not note any findings and/or questioned costs. A Management Letter was not issued as there were no matter of non-compliance or findings of deficiencies in internal control reported by the audit.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	The agency has policies and procedures for the confidentiality and 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 all 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 100%.** There are no corrective actions cited or recommendations made from the contract monitoring visit. Overall, the provider is performing Satisfactorily in meeting the fiscal and administrative terms of its contract. All of the indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

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

May 25-26, 2022

Compliance Monitoring Services Provided by

FOREFRONT

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	**Failed**
1.06 Client Transportation	**Satisfactory**

Percent of indicators rated Satisfactory: 80 %
Percent of indicators rated Limited: 0 %
Percent of indicators rated Failed: 20 %

Standard 2: Intervention and Case Management

2.02 Needs Assessment	**Satisfactory**
2.03 Case/Service Plan	**Satisfactory**
2.04 Case Management & Service Delivery	**Limited**
2.05 Counseling Services	**Satisfactory**
2.06 Adjudication/Petition Process	**Satisfactory**

Percent of indicators rated Satisfactory: 80 %
Percent of indicators rated Limited: 20 %
Percent of indicators rated Failed: 0 %

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	**Limited**
3.04 Log Books	**Satisfactory**
3.05 Behavior Management Strategies	**Satisfactory**
3.06 Staffing and Youth Supervision	**Failed**
3.07 Video Surveillance System	**Limited**

Percent of indicators rated Satisfactory: 40 %
Percent of indicators rated Limited: 40 %
Percent of indicators rated Failed: 20 %

Standard 4: Mental Health/Health Services

4.02 Suicide Prevention	**Failed**
4.03 Medications	**Satisfactory**
4.05 Episodic/Emergency Care	**Satisfactory**

Percent of indicators rated Satisfactory: 66.67 %
Percent of indicators rated Limited: 0 %
Percent of indicators rated Failed: 33.33 %

Overall Rating Summary

Percent of indicators rated Satisfactory: 66.67 %
Percent of indicators rated Limited: 16.67 %
Percent of indicators rated Failed: 16.67 %

Rating Definitions

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

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

Reviewers

Members

Keith Carr - Lead Reviewer Consultant-Forefront LLC on behalf of the Florida Network of Youth and Family Services
Teves Bush – Regional Monitor, Florida Department of Juvenile Justice
Scoundrel Oliver - Shelter Manager, Lutheran Service Florida Southeast
Mark Shearon - Chief Operations Officer, Arnette House

Methodology

This review was conducted in accordance with FDJJ-2000 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care/Health Services, and (4) Mental Health/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (Effective January 1, 2022).

Persons Interviewed

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

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	4	# Health Records
X	Logbooks	X	Key Control Log	4	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	14	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	9	# Training Records
X	Contract Scope of Services	X	Precautionary Observation Logs	10	# Youth Records (Closed)
X	Egress Plans	X		2	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts	1	# Other: ___
X	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

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

Surveys

0	# of Youth	8	# of Direct Staff	0	# of Other

Comments

Due to COVID-19, this review was conducted onsite **using the Modified QI Review Plan.**

Monitoring Purpose

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

Strengths and Innovative Approaches

Miami Bridge Youth and Family Services, Inc. (Miami Bridge) contracts with the Florida Network to operate the Children in Need of Services and Family in Need of Services (CINS/FINS) program in two locations, Miami Bridge - Central Shelter (MB) located in 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 who 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). Miami Bridge 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 successfully re-accredited by COA in 2021.

On May 25-26, 2022, Forefront LLC, on behalf of the Florida Network, conducted the annual Quality Improvement (QI) review of Miami Bridge's two program locations concurrently. Each program location was reviewed by a QI team consisted of a Forefront lead reviewer and three peer reviewers, including a Department of Juvenile Justice QI Regional Monitor. The last onsite QI reviews for Miami Bridge were conducted in November 2020 (Homestead) and December 2020 (Central). Follow up onsite re-reviews of the indicators documented as Failed in the 2020 QI reviews were conducted on June 8, 2021 at both program locations. Since the last QI reviews, the agency has experienced significant challenges and changes related to governance, leadership, staffing, programming, facilities, partnerships, and overall service delivery.

Miami Bridge experienced a loss of two Board members during the past year, and two Chief Executive Officers (CEOs) within a six-month period beginning in July 2021. Following the resignation of the first CEO on July 30, 2021, the Board engaged a national recruiting firm and undertook an extensive CEO recruitment effort. A new CEO was hired on August 23, 2021, and subsequently terminated from her position November 23, 2021. The Board immediately engaged an Interim Executive Director (IED) on December 13, 2021, to assume leadership, stabilize the organization, implement the Outcome Base Corrective Action Plan (OBCAP), and recruit a new CEO and leadership team, working closely with the President on all matters. Since the engagement of the IED, the OBCAP is moving toward completion except for executive leadership recruitment. With the uncertainty of the Florida Network contract, the plan to recruit a new CEO is on hold until the organization determines what its business model and operating plan will be moving forward. The Executive Committee is serving as the Succession Planning Committee and will define the CEO role and what skills are needed within that role. To ensure continuous coverage of the critical CEO duties, the IED will serve until a new CEO is in place and will facilitate succession planning in conjunction with the President and the transition of a new CEO.

The current Chief Program Officer (CPO) was hired on November 1, 2021, in a consulting capacity. The CPO will serve in this role until such time as the status of the Florida Network contract is determined and the organization sustains or adopts a new operating plan/business model. The role can then be defined for a chief clinical director.

The current Chief Operating Officer is transitioning to a consulting position effective July 1, 2022, and will oversee the completion of key capital projects, continue to support operations where needed, and transition operational duties. Recruitment of a facilities manager is being untaken, and the COO will train and effect a smooth transition of this position.

The Central Shelter director has transferred to the Homestead Shelter where she is working as co-shelter director with the Homestead Shelter manager. The Central Shelter was closed from receiving clients due to insufficient staffing levels. During this interim period, until the Central Shelter can be re-opened, a major focus has been placed on building consistency in training, supervision, programming, scheduling, and procedures.

Miami Bridge has representation at all Circuit Advisory Board (CAB) meetings. A workgroup consisting of DJJ programs, community-based programs and Department of Children and Families convened to discuss how the community can take a more preventative approach and identify children and their families earlier in the service delivery phase to address behaviors that could be future deep-end issues. The first formal meeting of this year was held 5/11/2022 and will continue bi-weekly through 8/22/2022. Similarly, Miami Bridge is participating in Bridging the G.A.A.P., an ongoing discussion on youth and law enforcement regarding community relations, policies, viewpoints, and perspectives. This is a collaborative project between DJJ Office of Preventative Services and CMB Visions Unlimited.

The following improvements were made, or are in process or planning stages at the Central Shelter facility:

- The Central Shelter site is utilizing an application to capture mileage and other transportation events for the vehicles being used by the agency that are provided by the Florida Department of Transportation.
- The agency received CDBG HUD capital funds to be used by Miami Bridge Youth and Family Services for shelter projects.
- The agency is in the permitting process with architect/engineer to fix gas, line install drain and make code updates to accommodate new kitchen equipment scheduled to be installed.
- New kitchen renovations and kitchen equipment installation and gas line updates via Community National Bank.
- Department of Agriculture National School Lunch Program grant awarded $95,000 of new commercial kitchen equipment including stove, steamer, freezer, two refrigerators, commercial toaster, and a new ice machine for each shelter.

New programming partnerships include: 1) life sciences program- a partnership with Manifezt Foundation that focuses on science programs for youth. 2) Circle of Brotherhood that provides a mentoring program for young black men. Current non-CINS activities that complement the CINS program are the Nurturing Parenting Program funded through the Children's Trust, the Basic Center Program funded through HHS, and the Host Home Program funded through State Appropriations.

Narrative Summary

Miami Bridge Youth and Family Services, located at 2810 N.W. South River Drive, Miami, FL 33125, is under the leadership of a Board of Directors, interim Executive Director, Director of Finance, Chief Programming Officer, Chief Operating Officer, Director of Admissions, and two Shelter Managers, one of which is also the program's Registered Nurse. The Interim Executive Director oversees Miami Bridge and services provided in Central Miami and Homestead, Florida. At the time of this onsite program review, the agency's Central program site is not serving youth due to experiencing major challenges in maintaining existing and recruiting new direct care staff members. For the purposes of this review, the review period was extended to allow a review of agency's practice while youth were onsite. There are several vacant staffing positions specific to the Central program site that include a Human Resource (HR) Specialist, recreation coordinator, QI/Training manager, licensed clinician, facilities coordinator, residential counselor, and youth care workers.

An anonymous staff survey was provided to all current employees via email to voluntarily complete. Eight staff surveys were completed. Three residential staff and five community counseling surveys were returned. Staff were asked 'In the past year, how have the working conditions been in your program' with options ranging from 'Very Good' to 'Very Poor' or they could provide an individual response. There were two responses rated as 'Very Good', one response rated as 'Good', two responses rated as 'Fair', one response rated as 'Poor', one response rated as 'Extremely Poor', and one response rated as 'Needs Improvement'. Six out eight staff reported they have NOT observed a co-worker using threats, intimidation, or humiliation when interacting with a youth. Two out of three staff reported observing a co-worker using profanity when speaking to a youth. All eight staff surveys reported they were trained on child abuse reporting and would report any knowledge or suspicion if a child was being abused or neglected. One staff added an additional comment requesting assistance, concerns of leadership knowledge of operations, and the treatment of staff. No youth surveys were collected at this location because the program was not accepting youth at the time of review.

The overall findings for the modified Quality Improvement (QI) Review for Miami Bridge Central are summarized as follows:

Standard 1:

A total of five indicators were reviewed for Standard 1 regarding Management Accountability. Two of the five indicators were rated Satisfactory with no exceptions (1.02 and 1.03) and two were rated Satisfactory with exceptions (1.01 and 1.06). Indicator 1.04 received a Failed rating. The explanation for the Failed ratings is provided below.

Standard 2:

Five indicators were reviewed for Standard 2. One of the five indicators were rated Satisfactory with no exceptions (2.06) and indicators 2.02, 2.03, and 2.05 were rated Satisfactory with exceptions. Indicator 2.04 received a Limited rating. The explanation for the Limited rating is provided below.

Standard 3:

Five indicators were reviewed for Standard 3. Two of the five indicators were rated Satisfactory with exceptions (3.04 and 3.05). Indicators 3.01 and 3.07 received a Limited rating. Indicator 3.06 received a Failed rating. The explanation for the Limited and Failed ratings is provided below.

Standard 4:

Three indicators were reviewed for Standard 4. Indicator 4.03 was rated Satisfactory with no exceptions. Indicator 4.05 was rated Satisfactory with exceptions. Indicator 4.02 received a Failed rating. The explanation for the Failed rating is provided below.

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

Standard 1:

Indicator 1.04 Training Requirements – Failed

Failed Exception:

• None of the first year staff had evidence to support they completed the minimum number of training hours.
• Three of the first-year staff did not complete the following pre-service training within the required timeframe.
• One staff was hired on 2/2/21 and did not complete behavior management within the required timeframe.
• Three annual staff Failed to complete the required annual training hours requirement of 40 hours, which is required for programs with a DCF child caring license.
• All 4 annual staff files reviewed lacked documentation to support training was completed or within the required timeframes.

Standard 2:

Indicator 2.04 Case Management and Service Delivery – Limited

• The agency did not have residential counseling staff positions filled since November of 2021. Four of the eight records reviewed did not have a consistent identification of a residential counselor being assigned to the youth cases.
• Four of the eight cases do not have evidence of established referrals based on needs. All four residential cases do not document family's progress in addressing services. The files reviewed have limited evidence of monitoring progress of cases and parent/guardian engagement toward completing assigned goals. There is no documentation of 30 day follow ups after discharge in three of the four residential client files and no documentation of 60 day follow ups after discharge in four of the four closed residential client files.

Standard 3:

Indicator 3.01 Shelter Environment – Limited

• Facility entrance was soiled with bird droppings. Bathroom counters were not clean. Ants crawling on walls near emergency lights in the dayroom. The lint catcher in the dryer vent was not clean to prevent a possible fire hazard. Excessive dust was observed on all return air conditioning vents. Mold was found in the girl's restroom ceiling. Graffiti was observed on the bookshelves in the dorm and the linen closet.

Indicator 3.06 Staffing and Youth Supervision – Failed (This indicator was rated Limited during the last full QI review)

• A review of the work schedule indicates that the agency did not have staff listed on the schedule and in documentation in the logbook that provides evidence of maintaining minimum staffing ratios across work shifts as required.
• The following dates indicate a lack of documented evidence that the agency maintained a minimum of 2 staff on duty on the designated work shift.
• A review of bed checks resulted in evidence of 15-minute bed checks missed during sleeping periods from August 2021 through February 2022.

Indicator 3.07 Video Surveillance System – Limited

• There were no signs posted throughout the shelter informing visitors and residents that the shelter was under video surveillance.
• The agency's COO verbally provided a list of authorized users and their privileges. The list includes the COO and two Shelter Directors, who have limited privileges consisting of viewing privileges only.
• Supervisory reviews of the video camera surveillance system exceeded the 14-day review period multiple times.

Standard 4:

Indicator 4.02 Suicide Prevention – Failed

• Three out of four suicide screening results were not reviewed and signed by the supervisor and documented in the youth's case file.

• There is no evidence provided by the agency regarding Banyan staff who are contracted to provide clinical services needed from a licensed professional are licensed or background screened. When evidence was requested from Banyan to verify licensure of all staff, none was provided to verify and confirm this requirement. Further, clinical services required to be provided by a licensed professional, as required by the indicator, such as could not be validated. In addition, four of five suicide screening results were not reviewed and signed by the supervisor and documented in the youth's case file.

• Two client files do not have evidence of Observation logs that verify the status of the youth on elevated supervision.

• Two client files do not have evidence of the supervision level being changed by a licensed professional or counselor under the supervision of a licensed counselor.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators: Add an "**X**" in the applicable column *Satisfactory* *Non- Compliant (E.g. Exceptions)* ***No Eligible Items for Review*** ***No Practice*** ***Not Applicable***	**Satisfactory (S)**	**Non-compliant (E)**	**No Eligible Items for Review (N)**	**No Practice (NP)**	**Not Applicable (N/A)**	**Review Based Upon Document Source** *For example: Interview/Surveys, Observation, and/or Type of Documentation*	**Notes** **Explain any items that have any deficiencies, exceptions or are not applicable.**
Standard One – Management Accountability							
1.01: Background Screening (BS) and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						**YES** If NO, explain here: Policy 1.01 Recruitment and Background Screening of Employees, Volunteers and Interns implemented on 10.1.02 and reviewed/ revised on 5/15/22.	**Add any exceptions below:**
Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation for staff hired with a non-passing/low score.	**X**					A review sample of nine applicable newly hired staff training records verified each contained a completed pre-employment suitability assessment through Berke Assessments with a passing score.	
Background screening completed prior to hire/start date or exemption obtained prior to working with youth (if rated ineligible) for new hires, volunteers/interns, and contractors		**X**				A review of ten newly hired staff since the last annual compliance review verified the program completed an initial background screening prior to hire on nine of the staff.	Exception: One staff background screening was completed 144 days after hire.
Agency has evidence for employees who have had a break in service and who are in good standing and reemployed with the same agency without an additional suitability assessment or background screening if the break is less than 90 days.	**X**					None of the newly hired staff had a break in service.	
Five-year re-screening completed every 5 years from initial date of hire	**X**					Three staff were eligible for a 5 year re-screening. A review of Clearinghouse validated the program obtained a rescreening on three of the staff within their one year anniversary.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**X**					The program has an Affidavit of Compliance Level 2 Screening signed by the BSU on 1/20/22.	

Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					A review of ten newly hired staff personnel records verified each received an employee verification from the Department of Homeland Security.	
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** If NO, explain here: Policy 1.02 Provisions of an Abuse Free Environment implemented on 10/1/02 and revised on 1/1/21.	**Add any exceptions below:**
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Abuse Free Environment							
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	X					Staff are provided a copy of the employee code of conduct which is reviewed during the orientation process for new hires.	
Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	X					Observation of the program indicated the Florida Abuse Hotline telephone number is posted in the living area for both the girls and boys residential sleeping quarters.	
Youth were informed of the Abuse and Contact Number (see youth survey results)	X					The agency provides an orientation handbook to all youth admitted to the program. A review of the handbook indicated the Florida Abuse Hotline number is included.	
Management takes immediate action to address any incidents of threats or abuse	X					The agency has a policy in place which addresses matters related to possible abuse. A review of the Central Communications Center (CCC) reports for the past six months along with incident reports verified there were no instances of staff abuse against a youth. Youth are given unimpeded access to make an abuse call if they feel they have been abused. The program maintains an abuse call binder which captures telephone calls to the Florida Abuse Hotline.	
Grievance Process							
Agency has a formal grievance process	X					The program provides a grievance process which is accessible, responsive, and provides feedback regarding the resident submitting the grievance.	
Locked box accessible to only management and available to youth in a common area	X					Observation of the facility indicated a locked grievance box which is located in dayroom area.	
Direct care does not handle the complaint/grievance unless assistance is asked for by the youth. Program director/supervisor will have access to and manage grievances unless it is towards themselves.	X					The residential service director handles all grievances. An informal interview with the residential service director indicated there were no grievances submitted since the last annual Quality Improvement (QI) program review.	

72-hour resolution requirement by management. If this does NOT occur within the 72 hour period, there is sufficient documentation explaining the cause for the delay in resolution.	X					An interview with the residential service director was conducted. The director reported there has been no grievances reported by residents since the annual program review.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						**YES** If NO, explain here: Policy 1.03 Incident Reporting implemented on 10/1/02 and reviewed/revised 5/15/22.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	X					A review of the CCC reports from the last six months was completed. Each incident reported to the CCC was were reported within the required 2 hour timeframe.	
The program completes follow-up communication tasks/special instructions as required by the CCC	X					A review of the CCC reports verified the program completed follow-up communications tasks and special instructions.	
Incidents are documented in the program logs and on incident reporting forms	X					The program maintains a binder which contains internal incident reports. A review of the CCC reports coupled with the corresponding incident reports verified a report was created for each CCC generated.	
All incident reports are reviewed and signed by program supervisors/directors	X					Review of the incident reports for the past six months verified they are reviewed and signed by the supervisor.	
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** If NO, explain here:	**Add any exceptions below:**

						Policy 1.04 Training Requirements implemented on 10/1/2002 and reviewed/revised on 5/15/2022.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
First Year Direct Care Staff							
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. *(Staff hired before January 1st were required to complete no later than December 31, 2020)*		X				Four pre-service training records were reviewed and one completed the required Civil Rights training within the 30 day timeframe.	Exception: Three of the four staff training records reviewed did not contain evidence the DOJ Civil Rights training was completed within 30 days as required.

All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				Four staff training records indicated all required training was not competed within the ninety day timeframe.	Exceptions: One staff was hired on 11/29/21 and did not complete the following pre-service training within the required timeframe: Understanding youth/ adolescent development, CPR and first aid, confidentiality, child abuse reporting (SkillPro), information security awareness, EEO, and human trafficking. One staff was hired on 11/8/21 and did not compete the following pre-service training within the required timeframe: Civil rights, understanding youth/ adolescent development, child abuse reporting, confidentiality, child abuse reporting (SkillPro), information security awareness, EEO, sexual harassment, suicide awareness prevention, and human trafficking. One staff was hired on 10/4/21 and did not complete the following pre-service training within the required timeframe: Civil rights, managing aggressive behavior, suicide prevention (FN), CINS/FINS Core training, signs and symptoms of mental health and substance abuse, understanding youth/ adolescent development, child abuse reporting, CPR, first aid, confidentiality, universal precautions, child abuse recognition, reporting and prevention (SkillPro), information security awareness, EEO, PREA, sexual harassment, trauma informed care suicide awareness and prevention (SkillPro), human trafficking, fire safety, LGBTQ, and cultural diversity. One staff was hired on 2/2/21 did not complete behavior management within the required timeframe.

Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training					X	At the time of this onsite program review, The program had no non-licensed mental health clinical staff to review for their adherence to the requirements of this indicator.	
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).					X	The program had no non-licensed mental health clinical staff requiring pre-service training.	
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).*		X				A review of four in-service training records indicated one staff completed the required training hours. However, these staff did not complete all the mandatory training topics for the 2021 calendar year.	Exceptions: 3 of 4 staff files reviewed did not have the required 40 annual refresher training hours. One staff did not complete suicide prevention (FN). One staff's CPR and first aid expired on 4/2/22, and child abused recognition, reporting and prevention was not completed. One staff did not complete suicide prevention (FN). One staff did not complete the required number hours of training and did not complete all the mandatory in-service training topics of suicide prevention (SkillPro), suicide prevention (FN), human trafficking, and child abuse recognition, reporting and prevention (SkillPro).
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.		X				A review of four staff in-service and four new hire training records was reviewed for compliance with this requirement. The program maintains training credentials and certifications, however, the supporting documentation was not consistent across all files.	Exception: Documentation to evidence all completed trainings was not consistently recorded and maintained in staff training files as required.
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES** If NO, explain here: Policy 1.06 Transportation and Vehicle Management implemented on 10/1/02 and reviewed/revised on 5/15/22.	**Add any exceptions below:**

Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					The agency maintains a list of staff approved by the program to transport youth.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	X					The program has a list of approved drivers who have a valid driver license and is insured under the program's automobile insurance policy. Driving records are checked by the insurance company once the staff are identified by the program as an authorized drivers. The driving records of staff members are checked with the Florida Department of Highway Safety and Motor Vehicles (FLHSMV) annually on all authorized drivers.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	X					When youth are transported, a third party is utilized. If a third party is not available, authorization is given by administration for the youth to be transported with an individual staff.	
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		X				The agency has a policy that states authorization should be given by the administration if a single youth transport is needed. The program had one instance were a single staff transported a youth without authorization from administration. The program had no other instances which did not provide a third party to assist with transport.	Exception: One youth single transport was observed, however, there was no documentation of prior authorization from a supervisor. A review of the documentation indicated the staff was reprimanded and retrained on the program's policy. Soon after, the staff resigned.
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					The agency has a policy that acknowledges a third party may be used for transportation and can include: an approved volunteer, intern, agency staff, or other youth.	
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.	X					When transporting, staff document in the program logbook the vehicle being used, name or initials of driver and third party, date and time of transport, mileage, number of passengers, location, and purpose of transport. A review of log notes for six different days verified this practice.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						**YES** If NO, explain here: The agency has the required policy and procedure 2.02 that was approved May 15, 2022 by the interim executive director.	**Add any exceptions below:**
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Completion of NIRVANA							

Shelter Youth: NIRVANA initiated (or attempted) within 72 hours of admission	X					A random sample of eight client case records were reviewed to assess the agency's adherence to the requirements of this indicator. Of these client case files, four were residential (four closed cases) and four were non-residential client cases (2 open and 2 closed cases). At the time of this onsite program review, the agency was not actively providing care for eligible clients at the central program's youth shelter in Miami, Florida. The sample of residential client files reviewed included closed cases from the past 90-120 days. Two of these residential cases were opened after January 1, 2022, and did have evidence of the NIRVANA assessment tools being initiated. These two cases contained a NIRVANA Self-Report (NSR) completed within 24 hours of the youth being admitted into the shelter.	
Non-Residential youth: NIRVANA is done within 2 to 3 face-to-face contacts after the initial intake	X					A total of six applicabe client files (2 residential and 4 non-residential) have evidence of completed NIRVANA assessments that were completed following the initial intake session. All six client files met the criteria for the NIRVANA and were opened after to January 1, 2022. Two client files were residential files that were opened prior to January 1, 2022 and contained traditional needs assessments.	
NIRVANA is conducted by a bachelor's or master's level staff member	X					At the time of this onsite program review, the staff administering NIRVANA assessments have a minimum of a bachelor's degree or higher. The central shelter, residential counselor, position has been vacant since November 2021. The agency has staff members from community counseling and counseling staff completing client file case work as needed.	
Supervisor signatures are documented on either the completed NIRVANA, interview guide and/or the chronological note that is located in the youth's file.		X				Supervisor signatures are documented on the non-residential client files on the NIRVANA assessment. Two of the four residential client files has documented supervisor signatures.	Exception: Supervisor signatures are missing in 2 of 4 residential client files dated 1/14/2022 and 1/18/2022 reviewed.
Shelter Youth: The NIRVANA Self-Report (NSR) is completed within 24 hours of youth being admitted into shelter.	X					There is evidence of the NIRVANA Self-Report being completed in 2 of the applicable residential client files. These client files contained a NIRVANA Self-Report (NSR) completed within 24 hours of the youth being admitted into shelter.	

A NIRVANA Post-Assessment is completed at discharge for youth who have a length of stay that is greater than 30 days or there was evidence that a NIRVANA Re-Assessment occurred within 30 days of discharge.			X			The sample of client files for closed cases did not have applicable cases with the post-assessment discharge period with documentation of length of stay that is greater than 30 days or a NIRVANA Re-Assessment that took place within 30 days of discharge.	
A NIRVANA Re-Assessment is completed every 90 days with the exception of SNAP services.			X			The sample of client files for closed cases did not have applicable cases with the re-assessment that is completed every 90 days.	
Suicide Risk as a Result of the NEEDS Assessment							
Youth was identified with an elevated risk of suicide as a result of the Needs Assessment			X			The eight residential and non-residential client files reviewed for indicator 2.02 did not have youth screened positive for being at risk for suicide. None of these casees required elevated supervision.All eight case reviewed and all cases contained evidence that each of these youth were properly screened, however the screening result did not require review of a licensed mental health professional.	
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			X			The eight cases reviewed do not have youth that are screened and indicate positive for being at risk for suicide. All eight cases reviewed contained evidence that the screening result did not require a referral for assessment of suicide be conducted under the superviision of or by a licensed mental health professional.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES** If NO, explain here: The agency has the required policy and procedure 2.03 that was approved May 15, 2022 by the interim executive director.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Case/Service plan is developed within 7 working days of NIRVANA		X				A random sample of eight client cases were reviewed to assess agency's adherence to this indicator. Of these client case files, four were residential (four closed cases) and four were non-residential client cases (2 open and 2 closed cases). At the time of this onsite program review, the agency was not actively providing care for eligible clients at the central program's youth shelter in Miami, Florida. Service plans were developed in six of the eight records reviewed. Four of the six applicable cases contained service plans that have evidence of being devloped within seven working days of NIRVANA.	Exception: Two of the six applicable cases contained service plans that did not have evidence of being developed within seven working days of NIRVANA.
Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated		X				Seven of eight client files have evidence of individualized needs and goals related to problems identified by NIRVANA. Seven client files include evidence of service type, frequency and location, as well as person responsible. Four of the eight client files contained evidence of target dates. Four of the eight client files had documented proof of actual completion dates. Four of the eight files contained youth signatures in the case records. Evidence of youth signatures were found in seven files. Evidence of parent/guardian signatures were found in four of the eight records. Evidence of counselor signatures were found in the eight reviewed client files. Case notes indicated the parent/youth participated in four of the eight cases. Case notes include agency providing virtual and or telephone approval as the youth and parent attended remotely due to COVID-19 and therefore not physically present to sign the service plans. The agency did not have a residential counselor at the Central program site from November 2021 to present. Non-residential staff members provided assistance in serving these clients, as well as maintining their regular case loads.	Exceptions: One client file does not contain a completed service plan. One of the eight client files does not have evidence of individualized needs and goals related to problems identified by NIRVANA. Evidence of parent/guardian signatures were not found in four of the eight client records. Four of the eight client files did not contain evidence of target dates. Three out of the eight client files did not have documented proof of actual completion dates. Evidence of parent/guardian signatures were not found in four of the eight records.
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	X					Three of the four non-residential records were reviewed and revised every 30 days as required. There is evidence of documentation in the three service plans being reviewed for progress by counselor and parent every 30 days. One of the four applicable client files did not have evidence of service plan reviews every 30 days. This case was closed after numerous documented attempts to try to engage youth and parent.	

Provider has a written policy and procedure that meets the requirement for Indicator 2.04						YES If NO, explain here: The agency has the required policies and procedures 2.04 and 2.04.01 that were approved on May 15, 2022 by the interim executive director.	Add any exceptions below:
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Counselor/Case Manager is assigned		X				A random sample of eight client cases were reviewed to assess the agency's adherence to the indicator. Of these client case files, four were residential (four closed cases) and four were non-residential client cases (2 open and 2 closed cases). At the time of this onsite program review, the agency was not actively providing care for eligible clients at the Central program's youth shelter in Miami, Florida. The agency reported they did not have staff fulfilling the role of residential counselor since November of 2021. Four of the eight records reviewed showed a counselor was assigned to the youth.	Exception: The agency did not have residential counseling staff positions filled since November of 2021. Four of the eight records reviewed did not have a consistent identification of a residential counselor being assigned to the youth cases.
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitors out-of-home placement (if necessary) 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit		X				Six of the eight client files reviewed to assess this agency's adherence to this indicator demonstrated applicable case management services were provided as needed and progress is monitored. One of the eight cases was discharged early due to lack of participation from youth and family. There is evidence of consistent practice related to referrals, service plan implementation, monitoring of progress, and family progress and support observed in three of the eight client files reviewed. Four of the eight cases (1 residential and 3 non-residential) have evidence of established referrals based on needs and coordinates accordingly. Three of the four non-residential cases were not eligibile for 30, 60 day follow-ups after discharge as of the date of this onsite program review. No residential cases required out-of-home placement or attendance by the agency in court-related proceedings.	Exceptions: Four of the eight cases do not have evidence of established referrals based on needs. All four residential cases do not document family's progress in addressing services. Cases have limited evidence of monitoring progress of cases and of parent/guardian engagement toward completing assigned goals. There is no documentation of 30 day follow ups after discharge in three of the four residential client files and no documentation of 60 day follow ups after discharge in four of the four closed residential client files.

The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	X					The agency reported it has active written agreements with community partners that include DJJ Office of Preventative Services, CMB Visions Unlimited, AMI Kids, Boys and Girls Clubs and PACE Center for Girls, (Community Health of South Florida, Manifezt Foundation, and Circle of Brotherhood.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						**YES** If NO, explain here: The agency has the required policy and procedure 2.05 that was approved May 15, 2022 by the interim executive director.	**Add any exceptions below:**
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Youth and families receive counseling services, in accordance with the youth's case/service plan, to address needs identified during the assessment process	X					A random sample of eight client cases were reviewed to assess the agency's adherence to the indicator. Of these client case files, four were residential (four closed cases) and four were non-residential client cases(2 open and 2 closed cases). At the time of this onsite program review, the agency was not actively providing care for eligible clients at the central program's youth shelter in Miami, Florida. Six of the eight records were applicable and demonstrated individual and/or family counseling as needing counseling services. Two youth were not applicable for counseling services.	
Shelter Program							
Shelter programs provides individual and family counseling	X					Progress notes contain evidence and demonstrate all four applicable youth were listed as needing individual and/or family counseling services as identified during the assessment and shelter stay. All youth plans have notes indicating attempts to schedule counseling.	
Group counseling sessions held a minimum of five days per week	X					The agency is required to provide group counseling sessions to shelter residents a minimum of five days a week. At the time of this onsite program review, the agency was not actively providing care for eligible clients at the central program's youth shelter in Miami, Florida. No observation of this practice was observed during this onsite program review.	

Group counseling sessions consist of: a. Length of at least 30 minutes b. Opportunity for youth engagement c. Clear and relevant topic (informational/developmental/ educational) d. Clear leader or facilitator	X					The agency provided documentation related to group session activity. The review of the group schedule and group sign-in logs for October 2021 through January 2022. The agency documents show sign-in logs for groups sessions that were conducted. Sessions document a minimum of 30 minutes in duration. Groups indicated that they were conducted by direct care staff and other staff members. Group session topics cover multiple issues and topics related to educational topics, mental health, family, youth development, decision-making, grief and loss and other topics.	
Community Counseling							
Community counseling 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, the local provider's counseling office or virtually if written documentation is provided in the youth's file for reasons why it is in the best interest of the youth and family.	X					A review of four applicable community counseling records was conducted. All four cases contained documentation that indicated that counseling services were provided based on the specific presenting problems, as well as issues discovered during the screening process. Services were provided through various methods such as the home, community, telephone and via virtual meeting methods services to ensure that families issues were addressed.	
Counseling Services							
Reflect all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up	X					A review of all 8 client files was conducted. The agency utilizes an electronic records management system called the Lauris Online system for all client files. Seven of eight client files contains major screening, intake, assessment, service planning and case notes are in each record accordingly. An individual youth services record was not found in one file due to youth being discharged prior to the initiation of the service planning process.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	X					A review of eight client files found all files contained an individual client record in the Lauris Online electronic client file system.	
Case notes maintained for all counseling services provided and documents youth's progress	X					A review of eight client files found all files contained legible case notes in the Lauris Online electronic client file system and individual case notes were found for each youth.	

On-going internal process that ensures clinical reviews of case records and staff performance		X				There were four applicable youth residential records and four community counseling records reviewed. Legible case notes are maintained in Lauris Online and individual records are validated for each youth. None of the cases had evidence of consistent reviews of practice by a clinician. At the time of this onsite program review, the agency clinician position was vacant and was being temporarily filled and outsourced to Banyan Health Systems. The agency reported that Banyan Health Systems is only contracted to provide licensed clinicians on an on-call basis and is utilized by the agency to assess youth placed on elevated supervision after being screened positive for suicide risk. There is record of supervisor signatures of assessments and/or service plan reviews only.	Exception: The agency is not conducting clinical reviews of client case files. At the time onsite review, the agency does not have a part-time or full-time licensed clinician on staff to review the status of case records and staff performance.
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						**YES** If NO, explain here: The agency has the required policy 2.06 that was approved May 15, 2022 by the interim executive director.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Case Staffing Initiation and Notifications							
If parent/guardian initiates, staffing is held within 7 days	X					A review of three applicable case staffing clients from August 2021 - May 2022 were reviewed to assess the agency's adherence to the indicator. All three cases have evidence that the staffing was initiated within 7 days of the parent/guardian's request.	
The youth, family and case staffing committee are contacted within a minimum of five working days a. Notification to youth/family no less than 5 working days prior to staffing b. Notification to committee no less than 5 working days prior to staffing	X					All client files have documentation indicating the youth, family and committee are notified in 5 working days or less prior to the staffing meeting.	
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	X					All client files have documentation indicating a DJJ representative and local school representative are included in the staffing meeting. In all three cases, the CINS/FINS provider is documented as in attendance.	

Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**X**					All client files have documentation indicating system partners are included in the staffing meeting on a routine basis according to the circumstances of the case, presenting problems and other information discovered during the assessment and staffing process.	
The program has an established case staffing committee, and has regular communication with committee members	**X**					The agency CINS/FINS community counselor is the lead in organizing all meetings. The reviewer interviewed the counselor and confirmed that the counselor sets the schedule and system partners that are required to be notified for each meeting.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**X**					The agency has written procedures for facilitating the case staffing process that are described in detail in policy 2.06.	
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services	**X**					A review of the three cases provided in the sample indicate the youth and family had staffing meetings and all plans were updated and provided as required.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**X**					All cases indicated the counselor provided the parent and guardian with the required report that lists all updates including revisions, recommendations, and justification for any changes in interventions or service delivery.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**X**					The community counselor acts as the CINS/FINS representative and is assigned to facilitate case staffings. The agency's counselor is engaged with the local court proceedings regarding all CINS/FINS matters. The community counselor is working directly with working with the youth and family in all three of these cases.	
Case Manager/Counselor completes a review summary prior to the court hearing	**X**					The agency's community counselor is assigned to facilitate all case file updates related to case staffing. The counselor completes a review of the status of each case staffing prior to all meetings. All three cases, have evidence that all updates and summaries are properly provided to the youth, family and system partners as required.	

Provider has a written policy and procedure that meets the requirement for Indicator 3.01						YES If NO, explain here: The agency has the required policy and procedure 3.01 that was approved May 15, 2022 by the interim executive director.	Add any exceptions below:
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Facility Inspection		X				A facility inspection was conducted. All areas of the shelter were reviewed including day room, girls and boys dormitory sleeping areas, bathrooms and showers, kitchen and dining room, health specialist room, school, first stop counseling offices, administrative offices, and outside exterior areas. Transportation vehicles were also inspected. The last date of facility residential facility inspection was reviewed on1/30/21.	Exceptions: The entrance to the facility was soiled with bird droppings. Bathroom counters were not clean. Ants were observed crawling on wall in dayroom. The lint catcher in the dryer vent was not clean to prevent possible fire hazard. Excessive dust collected on all return air conditioning vents. Mold was found in the girls restroom ceiling. Graffiti was observed on the book shelves in the dorm, and in the linen closet.
Additional Facility Inspection Narrative (if applicable)	Upon entering the youth shelter, the Department of Health facility inspection form that was displayed was from November 2019. The reviewer brought this to the attention of the agency's Chief Operations Officer (COO). The reviewer requested a facility inspection that was more current. The COO produced an inspection from November 2021. Health inspections are conducted quarterly and the agency was not able to provide a recent and inspection upon the reviewer's initial request. The COO reported that the Health Department does conduct inspections of the facility, but not on a consistent basis. The reviewer informed the COO that the agency can also contact the Health Department and inform them that they are in need of their facility inspections to ensure that Miami Bridge is in compliance with its contract requirements. The agency was also not able to present a Group Care inspection. When the reviewer requested the Group Care Inspection from the COO, the COO was not familiar with this inspection report and the reviewer informed the COO on what type of inspection was needed. The reviewer later found the Group Care inspection in the documents with the Health Inspection from November 2021.						
Fire and Safety Health Hazards		X				Date of fire inspection(s) reviewed: 5/20/2022	
Additional Fire and Safety Health Hazards Narrative (if applicable)	The annual fire inspection was conducted on 5/20/22 and there were no violations observed at the time of the inspection. The agency conducts monthly fire drills based on the current standards. Of the 21 fire drills reviewed, 15 met the current standards.						Exception: One fire drill was missing and 6 fire drills exceeded completing the drill within 2 minutes or less.

Youth Engagement							
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	X					At the time of this onsite program review, the agency was not serving residents. The actitivity schedule was not posted. The agency reported not serving any clients in the facility since January 2022. The agency is currently faced with significant staffing issues to maintain sufficient staffing levels to operate the shelter. The Chief Executive Officer and the governance board are currently working to advertise, recruit and hire new staff, as well as working to reorganize the organization in order to reopen the shelter in the coming months. Four residential cases have evidence documented in each client file indicating participation in the program's dailiy acitivities inlcuding attending school, participating in groups, study time and homework, and recreation.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						**YES** If NO, explain here: The agency has the required policy and procedure 3.04 that was approved May 15, 2022 by the interim executive director.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Log book entries that could impact the security and safety of the youth and/or program are highlighted		X				The agency has an electronic logbook platform system used to document all activities, occurrences and other operations and program events. The platform captures all logged entries documented by users. A random selection of logbook entries were reviewed to determine if the agency is adhering to the requirements of the indicator for logged events and highlighting. A review of the logged entries indicated that entries for related security and safety were not highlighted as required. Entries for youth placed on sight and sound were not found to be documented in the logbook as required.	Exceptions: A review of the logged entries for safety and security events indicated entries were not docuemented in the logbook. Safety and security entries for placing youth on sight and sound observation were not found. Logbook documentation for removal from on sight and sound status indicating prior approval from licensed clinician not found in logbook.

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	X					A review of logbook entries was conducted for entries made into the logbook platform for the last six months. All entries made in to the platform include the date, time, event, occurrence and name of the person and signature. Each logged event indicates what the entry is about, signature and name of person making the entry.	
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.			X			No strike through errors we found in the review of the logbook platform.	
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	X					A review of the agency's logbook platform entries prior to January 2022 was conducted. The shelter is currently not providing services to clients. A review of the these entries resulted in evidence of the supervisors documenting review of logbook entries on a consistent basis. Remarks and follow up comments are documented.	
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	X					A total of five dates were selected for review; 8/16/21, 8/25/21,10/13/21,10/20/21,12/3/21 reflected staff acknowledgements of tablet reviews of the previous two shifts. These entries are highlighted in green in the electronic logbook platform.	

At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.		X				A review of the logbook platform did reflect the Supervisors weekly review of logbook review dates conducted by the supervisor. Specific dates reviewed by the Supervisor were 8/24/21, 9/7/21, 9/26/21, 1/2/21, and 2/7/21. There are no shelter counselor reviews of the logbook found during the review of the logbook platform. The Residential Supervisor reported that the agency utilizes another counselor from a different program. The agency reported that this is done sometimes to assist in seeing residents and whenever that counselor is onsite she will review the tablet for previous two shifts.	Exception: The agency logbook does not have documentation of shelter counselor reviews of the logbook across all shifts indicating exact dates when logbook was reviewed by the counselor.
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	X					There were no entries identifying home visits for the months of 08/2021, 09/2021 and 10/2021. However, there were verified entries for 11/29/2021, 11/30/2021 and 12/3/2021 and 12/10/2021. A review of a total of five dates (8/15,8/25,10/20,10/31 & 12/3) showed physical head counts were facilitated every 30 minutes. Physical head counts included youth names, times, date and location of youth. □	
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						**YES** If NO, explain here: The agency has the required policy and procedure 3.05 that was approved May 15, 2022 by the interim executive director.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program has a detailed written description of the BMS, and it is explained during program orientation	X					The agency has a detailed behavior management system (BMS) that describes its current method of engaging residents with a practice model that addresses various stages of their behavior.	

Behavior Management Strategies MUST include: a. Supervisors are trained 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		**X**				The agency's Shelter Director of the Central program provided detail on the agency's BMS. The Shelter Director reported youth who engage in positive behaviors, completion of daily tasks, group participation, chores and school work completion can earn up to 75 points daily. Further the agency reported the program's Recreation Specialist develops a calendar of incentized outings and activities usually posted in the shelters common area for youth. The agency's BMS also allows staff the ability to report violations and consequences of program rules/expectations result in loss of previously accumulated points, loss of leisure time and participation in outings and other activities. Additionally, the Shelter Director reviews daily point sheets weekly and addresses any concerns or need for refreshers in the program's staff meetings. At the time of this onsite review, there were no youth onsite for the reviewer to observe the staff engaging youth and applying the agency's behavior management system. A review of the four first year residential staff member training files was conducted. Two of the four files contained evidence of completeing BMS training. At the time of this onsite program review, the agency was not serving residents in the Central youth shelter. The agency reported not serving any clients in the facility since January 2022. The client files reviewed from October 2021 through January 2022 had limited documentation of the agency's application of their behavior management system on its residents.	Exception: There were no consistent documented examples of behavioral interventions, strategies to encourage participation, implementation of appropriate consequences and sanctions, counseling intervention and de-escalation techniques documented in the four residential client files reviewed.
Program's Use of the BMS							
All staff are trained in the theory and practice of administering BMS rewards and consequences		**X**				An interview was conducted with the agency's residential director regarding the status of its BMS. The residential director reported that it evaluates each staff member's ability to use its BMS by having new staff shadow existing staff during onboarding before they utilize it on residents.	Exception: Residential Director was unable to provide documentation or proof of Behavior Management System training and review of practice.

There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences			X			At the time of the program review, there were no active clients being served to review current behavior management practice being executed by direct care staff and supervisors. There were no examples of evaluation and providing feedback regarding staff member's utilization of the BMS rewards and consequences on residents being served in the youth shelter.	
Supervisors are trained to monitor the use of rewards and consequences by their staff			X			At the time of the program review, there were no active clients being served to review current behavior management practice being executed by direct care staff and supervisors. There were no examples of monitoring the use of rewards and consequences by direct care staff.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES** If NO, explain here: The agency has the required policy and procedure 3.06 that was approved May 15, 2022 by the interim executive director.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
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		X				Review of staffing schedules for the months of August 2021 through February 2022 failed to provide evidence that there were a minimum of two staff scheduled to provide adequate shift coverage on some first and second shifts. The reviewer noted that direct care staffing schedules for the month of December 2021 for the weeks beginning 12/19/21 - 12/31/21 listed scheduled staff for the Homestead south location, but no staff listed for Miami central location. The schedule simply noted "Central" with a ? for all direct care work shifts. There was no specific documentation or clarification regarding the specific dates a decision to transfer all Central clients to Homestead location.	Exception: A review of the work schedule indicates that the agency did not have staff listed on the schedule or in documentation in the logbook that provides evidence of maintaining minimum staffing ratios across all work shifts as required.

All shifts must always provide a minimum of two staff present		X				Review of the agency staff schedules were conducted. The staff schedule was extremely difficult to review and understand. An internal decision to reduce or suspend providing residential delivery of service was decided by management and the Board of Directors. This decision was made due to extreme staffing issues which again resulted in the transfer of all CINS/FINS youth to the Homestead location and discontinuation of onsite schooling and other services. All youth were attending community based schools. The reviewer could not validate or confirm the specific date the decision was made by leadership to transition all youth to the Homestead location. The Shelter Director stated the last confirmed discharge was on February 15, 2022, yet there are staff scheduled inconsistently at the shelter for dates after the aforementioned February date. Shelter leadership is also included in the ratios, but staffing schedules do not indicate this.	Exceptions: The following dates indicate a lack of documented evidence that the agency maintained a minimum of 2 staff duty on the designated work shifts. These dates include: - first shift and overnight shifts on 8/1/21, first shift 08/06/21, first shift 08/08, first shift 08/15, 08/18, first shift 08/20/21. - September - 5th (first & overnight), 12th - first shift, 19th first shift, - October 3rd first shift, 10th overnight, 17th on first shift. - Month of November 21st overnight, 25th on 2nd and on 3rd shifts, 27th on 2nd shift, 28th on 3rd shift. - December 2nd on 3rd shift, 4th on 2nd shift. - Month of January 17th - 31st only one staff scheduled on the first and overnight shifts. - In the month of February - 1st shift on the 13th, no one was scheduled for the central location on dates 14th 1st shift and on first shifts on the 8th & 19th.
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	X					A review of personnel information indicates all supervision and direct care staff are background screened as required and offered training topics and hours to enable them to meet the minimum training requirements.	
The staff schedule is provided to staff or posted in a place visible to staff	X					Staff schedules posted in multiple areas throughout the shelter to include Intake Office, Copy Room and Shelter Managers Office. Schedule also sent in advance to staff via group text.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed			X			At the time of the program review, there were no active clients or residential direct care staff at this youth shelter location.	

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		X				The youth shelter has two dormitory style sleeping quarters (Dorm A & B). Dorm A has a total of six bunkbeds which were in fair condition . Each bed had new linen that had been recently purchased. Postings of bed assignments, client/youth rights, expectations and responsibilities, daily activity schedules were posted. Dorm B had a total of four bunk beds in fair condition with new linen. Postings of client/youth rights, expectations and responsibilities, daily activity schedules were also visibly posted on the walls of the entrance on the interior of the dorm. The layout of both dorms provided easy observation of youth activity while in their rooms. A total of five dates were reviewed. A review of bed checks indicate evidence of missed 15 minute bed checks during sleeping periods from August 2021 through February 2022.	Exception: A review of bed checks resulted in evidence of 15 minute bed checks that were missed during sleeping periods from August 2021 through February 2022. On 8/3/21 at 11:58pm entry stating the bed check function failed and checks could not be completed. 08/18/21 two missed bed checks at 12:34 am and 2:08am were observed. On 1/10/21- three missed bed checks at 3:05am, 3:45am and 4:02am. Between 12/24/21-1/2/22 although there were no youth in the Central shelter as per Shelter Director. However, the tablet designated for Central location entries had bed check entries for Homestead due to the youth being on Christmas break. On 1/24/22, a total of six bed checks were missed at 2:30am Dorm B, 2:31am dormitory A, 4:01am Dorm B, 4:26am Dorm A& B. On February 1, 2022, several issues were noted; multiple bed checks were missed and there was a 39 minute delay between 1:39am and 2:18am, another 26 minute delay between 4:22am - 4:48am, and a 33 minute delay between 5:03am-5:36am. Missed bed checks at 7:42am on 2/14/21.
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						**YES** If NO, explain here: The agency has the required policy and procedure 3.07 that was approved May 15, 2022 by the interim executive director.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Surveillance System							

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		X				A review of the provider's surveillance system was conducted during the facility tour indicated that there were a total of thirty-two operational cameras located throughout the shelter facility's interior and exterior grounds. Camera monitor views showed clear and unobstructed views of the shelter's entrances, exterior perimeters and both recreational and common areas and in good working order. The camera backup battery allows for operation during power outages for up to two hours.	Exception: There were no signs posted throughout the shelter informing visitors and residents that the shelter was under video surveillance.
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?		X				No personnel list was provided by the agency.	Exception: The COO verbally provided a list of authorized users and their privileges. The list includes the COO and two Shelter Directors, who have limited privileges consisting of viewing privileges only.
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.		X				The practice of reviewing the supervisor's review of the video was conducted on documentation from August 2021-February 2022.	Exceptions: Dates reviewed: 8/9/21, 8/23/21, 9/14/21, 9/28/21, 10/13/21, 10/27/21, 11/10/21, 11/30/21, 12/8/21, 12/21/21, 1/7/22, 1/24/22, 2/7/22 and 2/23/21. Eleven surveillance review dates were logged in the agency's electronic logbook tablet. Reviews held in November 2021 exceeded 14 days by 6 days -11/10/21 and the other on 11/30/21. A review on 1/7/22 and again outside of the 14 day window on 1/24/22 exceeded the review period by three days. February reviews also exceeded the 14 day review period by two days 2/7/21 and 2/23/21. All entries included dates of review, comments and supervisor signature. Copies of Emails to COO were also included which detailed findings and/or concerns.
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	X					Reviews of events, general activities, occurrences and random samples of work shifts are documented.	

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	X					The agency does have a verbal process to provide video to need to know parties for investigations, work performance and other program-related issue.	
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained		X				All camera surveillance system operations and any malfunctions are reported directly to the COO. The COO then directly requests service repair from camera vendor. All repairs are facilitated within 24-48 hrs. Note: There has been one service call to the location on March 16, 2022. The issue that was reported includes one of two monitors were "fuzzy" with the picture showing an unclear. The assessment to repair the malfunctioning system states that a replacement of an HDMI cord necessary.	Exception: No binders or documentation were provided or appear to be maintained by the agency. Only an invoice for service charges was observed. The COO reported surveillance system is fairly new and is under three years old. There has not been any significant failures to the surveillance system that would effect safety and security.
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						**YES** If NO, explain here: The agency has the required policy and procedure 4,02 that was approved May 15, 2022 by the interim executive director.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Suicide Risk Screening and Approval							
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.		X				Four closed residential client files were reviewed to assess the agency's adherence to this indicator. At the time of this onsite program review, the agency was not serving children. One of the four suicide screening files had evidence of the screening results. These results were reviewed and signed by the supervisor and documented in the client's case file.	Exception: Three out of four suicide screening results were not reviewed and signed by the supervisor and documented in the youth's case file.
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					The agency's suicide risk assessment is in use and does not require the Florida Network to approve of its use. The reviewer contacted the Florida Network head office to verify this result of verification.	
Supervision of Youth with Suicide Risk							

Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	X					Four closed files were reviewed. All client files contained evidence that residents were placed on the appropriate level of supervision based on the results of the suicide risk assessment.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals		X				Of the four youth provided to the reviewer, only two of the youth had consistent log checks. Of the four client case files reviewed, two of the client files possess evidence indicating the status of the youth on supervision at an interval 30 minute observation checks.	Exception: Two client files do not have evidence of Observation logs that verify the status of the youth on elevated supervision.
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		X				Four closed client files were reviewed. The agency does not have a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional. Of the four youth provided to the reviewer, all indicate that they were seen by Banyan. As a result, the agency contracts with a third party entity called Banyan Health Systems that provides on-call clinical services.	Exception: None of the four youth records demonstrated suicide supervision level changes were authorized in the file. Two client files do not have evidence of supervision level being changed by licensed professional or counselor under the supervision of a licensed counselor. One client did not have an email documented in regards to their approval to show that the youth was actually seen by the clinician. The reviewer was not able to confirm that the person being sent by Banyan had the proper clinical credentials. Banyan is a privately owned on-call clinical service provider. Miami Bridge staff contacted Banyan via phone for the reviewer to conduct a conference call with Miami Bridge staff, a representative from Banyan, which happened to be the general counsel of Banyan, and the reviewer. The reviewer contacted Banyan to request background screening credentials for all licensed clinical staff used to review assessments and approve the status of youth either staying on suicide observation or stepping down for suicide risk. The general counsel for Banyan Health Services denied the request for this information. The reviewer was unable to verify and confirm the clinical credentials of each representative that was sent to the Miami Bridge Youth & Family Services Supervisor for the assessment and other clinical information as well as the status of the youth.
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES** If NO, explain here: The agency has the required policy and procedure 4.03 that was approved May 15, 2022 by the interim executive director.	**Add any exceptions below:**

Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
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. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Med-Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	X					The agency received the upgraded Pyxis medication cabinet system. The cabinet is located in a locked room that is only accessible with a key. There is a refrigerator available that is dedicated to medication that requires refrigeration. The medication cabinet is capable of storing all prescription medication, including narcotics, controlled, over-the-counter, and EpiPens, as needed. At the time of this program review, the agency was not providing services to youth. The agency did not have a Health Specialist active on duty. The current person in the position was out on Worker's Compensation. The keys are available and secured.	
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			X			An internal decision to reduce or suspend providing residential delivery of services. This decision was made due to extreme staffing issues which again resulted in the transfer of all CINS/FINS youth to the Homestead location and discontinuation of onsite schooling and other services. There were no youth served during this onsite program review. Youth have not been served at this location since January - February 2022.	
Medication Inventory							
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly			X			There were no current eligible cases available for review.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.			X			There were no current eligible cases available for review.	
Medication discrepancies are cleared after each shift.			X			There were no current eligible cases available for review.	

Provider has a written policy and procedure that meets the requirement for Indicator 4.05						YES If NO, explain here: The agency has the required policy and procedure 4.05 that was approved May 15, 2022 by the interim executive director.	Add any exceptions below:
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
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	X					The agency had one incident requiring off-site medical care in the last six months. This incident was evaluated and was determined this off-site emergency medical incident met all requirements of this indicator. There is evidence that parents have been notified, the incident has been logged as required and post discharge follow up instructions are contained in the client's file.	
All staff are trained on emergency medical procedures		X				The agency's training requirements include training on emergency medical procedures. A total of eight staff member training files were reviewed (four first year and four in-service). Two of the four first year staff members have evidence of completing CPR and First Aid and Universal Precautions in first 90 days. Three of the four staff members employed more than one year have evidence of completing CPR and First Aid.	Exceptions: Two of the four first year staff members do not have evidence of completing CPR, First Aid and Universal Precautions in the first 90 days. One of the four staff members employed more than one year do not have evidence of completing CPR and First Aid.
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	X					The agency has emergency equipment that is secured and accessible if needed. The agency has emergency equipment that includes a knife for life, wire cutters and first aid kits. The emergency equipment is located in the direct care staff office filing cabinet in the top drawer.	
First aid kit/supplies are fully equipped and inventoried	X					The agency does have first aid kits in the youth shelter and kits are also provided for each transportation vehicle and are required to be taken on all transportation events. The Residential Director reported that first aid kits are inventoried and replenished on a monthly basis by the Health Care Specialist. Inventory reviews are documented and located in the Health Care Specialist office.	