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,	

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						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	

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						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	

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						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.	

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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	

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						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	

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$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	

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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
Homestead, Florida

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	**Satisfactory**
2.05 Counseling Services	**Limited**
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	**Satisfactory**
3.04 Log Books	**Failed**
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: 20 %
Percent of indicators rated Failed: 40 %

Standard 4: Mental Health/Health Services

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

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

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

Marcia Tavares- Lead Reviewer Consultant, Forefront LLC
Rosa Flores – Regional Monitor, Department of Juvenile Justice
Tiffany Martin - Quality Improvement & Compliance Manager, Florida Network of Youth and Family Services
Nathaly Milla - Residential Coordinator, Florida Keys Children Shelter

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

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

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan		Youth Handbook
X	CCC Reports	X	Grievance Process/Records		# Health Records
X	Logbooks		Key Control Log	5	# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log	17	# Personnel /Volunteer Records
X	Contract Monitoring Reports		Medical and Mental Health Alerts	6	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	12	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	4	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

	Intake	X	Posting of Abuse Hotline		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		Discharge		Group
X	Security Video Tapes		Treatment Team Meetings		Meals
	Social Skill Modeling by Staff		Youth Movement and Counts	X	Signage that all youth welcome
	Medication Administration	X	Staff Interactions with Youth	X	Census Board

Surveys

4	# of Youth	6	# of Direct Staff		# of Other		

Comments

Due to COVID-19, this review was conducted onsite using a 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 located in Miami and a south shelter located in Homestead, Florida (MB Homestead). Funding through CINS/FINS allows the agency to serve both male and female youth up to the age of 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 simultaneously. Each program location was reviewed by a QI team that consisted of a Forefront lead reviewer and three peer reviewers, including a Department of Juvenile Justice QI regional monitor. 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 indicators at both program locations. Since the last QI review, the agency has experienced significant challenges and changes related to governance, leadership, staffing, programming, facilities, and partnerships.

Miami Bridge experienced a loss of two Board members during the past year, and two Chief Executive Officers (CEO) 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. 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 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 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 Work Group 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 stage at the Homestead Shelter facility:

- Homestead First Stop for Families (FSFF) roof was replaced due to leaks.
- City of Homestead CDBG HUD capital funds that were awarded to MBY for shelter projects is back being renewed with City of Homestead commissioners
- Homestead Shelter grounds is scheduled for annual hurricane tree trimming/debris removal
- Homestead Metal roof damage repaired from tree damage
- Dorm, kitchen, medical office, youth hallway bathroom doors were all replaced
- Preliminary conversations concluded to begin 40 year building re-certification
- In permitting process with architect/engineer to fix gas, line install drain and make code updates to accommodate new kitchen equipment being installed in 40-year-old building.
- New kitchen floor and construction costs to support kitchen equipment installation and gas line updates via Community National Bank
- New dining tables, chairs, painting, lighting upgrades and tress alongside of perimeter fence in progress funded by AT&T Corporate
- 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) CHI (Community Health of South Florida) that provides substance abuse services (individual and group counseling) for youth at the Homestead Shelter; 2) life sciences program- a partnership with Manifezt Foundation that focuses on science programs for youth; and 3) 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 Homestead, located at 326 NW 3rd Ave, Homestead, Florida, 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. Seven vacant positions include a Human Resource(HR) Specialist, recreation coordinator, Quality Improvement (QI)/Training manager, clinical director, facilities coordinator, residential counselor, and youth care worker.

An anonymous youth survey was provided to all current CINS FINS youth to voluntarily complete. Four (4) youth surveys were collected at this location. All youth surveyed reported being informed about the abuse hotline and was able to show or tell where the number is posted. All youth reported feeling safe at the shelter and receiving an orientation about the program when they first arrived. All 4 youth surveyed selected "Yes" when asked if adults were respectful when talking to youth and stated "No" when asked if they have hear adults using curse words or threatening another youth in any way. All 4 youth survey responses state they are not denied food or clean clothing. All 4 youth wrote positive comments about the orientation process and being introduced to the shelter manager, staff and/or other kids.

An anonymous staff survey was provided to all current employees via email to voluntarily complete. Six (6) staff surveys were completed. 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 select "Other" and explain their individual response. There were five responses rated as "Fair" and one response rated as "Poor" . Four (4) out of six (6) staff reported they have NOT observed a co-workers using threats, intimidation, or humiliation when interacting with a youth. Three (3) out of four (4) staff denied observing a co-worker using profanity when speaking to a youth. All 6 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. Two staff left general comments at the end of the survey: "We need changes" and "Miami Bridge is a good place to work. The staff there really cares about the kids in their care".

<u>The overall findings for the modified QI Review for Miami Bridge Homestead is summarized as follows:</u>

<u>Standard 1</u>

Five indicators were reviewed for Standard 1 regarding Management Accountability. One of the five indicators was rated Satisfactory with no exceptions (1.02) and three were rated Satisfactory with exceptions (1.01, 1.03, and 1.06). Indicator 1.04 received a Failed rating.

<u>Standard 2</u>

Five indicators were reviewed for Standard 2. Three of the five indicators were rated Satisfactory with no exceptions (2.03, 2.04, and 2.06) and indicator 2.02 was rated Satisfactory with exceptions. Indicator 2.05 received a Limited rating.

<u>Standard 3</u>

Five indicators were reviewed for Standard 3. Two of the five indicators were rated Satisfactory with exceptions (3.01 and 3.05). Indicator 3.07 received a Limited rating and indicators 3.04 and 3.06 were rated as Failed.

<u>Standard 4</u>

Three indicators were reviewed for Standard 4. Two indicators 4.03 and 4.05 were rated Satisfactory with exceptions. Indicator 4.02 received a Limited rating.

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

Standard 1:

Indicator 1.04 – Failed

- One of the three first staff hired on 10/18/21 did not complete the civil rights training during the required 30-day time frame.
- None of the three first-year staff completed all mandatory training required during the first 90 days.
- Two of the three in-service staff did not complete all annual required training topics or within the timeframes required.
- Supporting training documentation was not consistently present for all training completed. Some training records were missing DJJ SkillPro transcripts, Florida Network Bridge transcripts, or certificates for MAB and/or CPR/First Aid.

Standard 2:

Indicator 2.05 – Limited

- One youth's service plan identified individual counseling as part of the youth's goal; however, there were no progress notes or case notes indicating counseling services were provided.
- Group counseling is to be provided at least 5 days a week. However, group logs reviewed showed groups not being conducted consistently 5 days a week, as required.

Standard 3:

Indicator 3.04 – Failed (This indicator received a Limited rating during the last full QI review)

- Reviewer observed inconsistency with highlighting logbook entries regarding sight and sound alerts. Sight and sound alerts were not highlighted in the logbook on November 6,7,8,10,12; January 8,9,10,16,17; February 14th; and May 14th, 2022.
- Director or designee does not review the logbook every week and make chronological notes in the logbook indicating dates reviewed. This indicator received a Limited rating during the last QI review for a similar finding. There were no weekly reviews for the vast majority of the review period from November 5th until December 20th, 2021; December 29th until March 13th; May 28th until April 5th. After periods mentioned. there were weekly reviews found until May 25th.
- Although there is a staff per shift who stated to have reviewed logbook, not all staff scheduled are indicating they have reviewed the logbook. Also, there are gaps on logbook review by staff between November 5th and May 25th.

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

- Transportation with youth was not found to be within ratio on February 17, 2022 where one staff was noted as transporting 8 youth.
- On April 24th between 12:15-2:00 a.m.,15-minute bed checks did not occur on the girl's dorm. Also, on April 30th between 2:00 a.m. and 3:00 a.m., 15-minute bed checks were skipped. Staff is seen on the video in both instances going down the hallway and scanning the barcode to indicate completing bed checks. At no instance did the staff go inside the girl's dorm, yet staff recorded bed checks as completed in the logbook.

Indicator 3.07 – Limited

- Video reviews have not been conducted at least once every 14 days between November 2021 and March 2022. Moreover, video reviews were irregularly conducted between March 14 to March 29; March 31 to April 19; and May 2nd to May 26.

Standard 4:

Indicator 4.02 – Limited

There is no evidence Banyan staff who are contracted to provide services needed from a licensed professional are licensed or background screened. When evidence was requested from the company to verify licensure of all staff, none was provided. Consequently, services to be provided by a licensed professional, as required by the indicator, 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.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators: Add an "**X**" in the applicable column	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: The agency has the required policy and procedure 1.01 that was approved May 15, 2022 by the interim executive director.	
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				The agency uses the Berke pre-employment suitability assessment with an established pass rate of medium to high. The Berke assessment was administered to five applicable new staff prior to hire but two of the staff received low non-passing scores on the assessment. No written explanation was documented prior to hire to support the hiring of staff with sub-score results. Upon request, explanations were provided during the QI review but were dated/issued long past the employees' hire dates, on 5/16/22 for staff hired 7/26/21 and an email explanation on 5/25/22 for staff hired 4/4/22.	Exception: Two new staff had non-passing low scores on the pre-employment Berke Assessment and were hired without an explanation from management regarding hire decision.
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 total of twelve background screening files were reviewed for five new hires and seven interns. All twelve background screenings were completed prior to start dates of the new hires and interns. The agency also contracts with Banyan Health Systems who supplies licensed professionals as needed to conduct clinical services and supervision of non-licensed clinical shelter staff completing assessments of suicide risk. However, no background screening documentation was completed for the contracted providers.	Exception: The agency did not complete background screening or obtain proof of eligible screening for licensed employees working for the contracted agency.
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 five new hires were prior Miami Bridge employees.	

Five-year re-screening completed every 5 years from initial date of hire	X					The program had five applicable 5-year rescreening during the review period. All five staff had evidence of valid retained prints in the Clearinghouse.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	X					Provider emailed the Annual Affidavit of Compliance with Level 2 Screening form to DJJ BSU on 1/20/2022, prior to the January 31st deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					E-verify and proof of employment authorization from the Department of Homeland Security was documented for all five new hires.	
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: The agency has the required policies and procedures 1.01 (Abuse Free Environment), and 1.02.01 (Grievance Process) that were approved May 15, 2022 by the interim executive director.	
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					Miami Bridge's new employee handbook includes the code of conduct and an acknowledgement of receipt for employees to sign. The signed acknowledgement goes in the employee's personnel file.	
Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	X					During a tour of the facility, the Florida Abuse Hotline number was observed to be posted on the walls in the counseling hallway and on walls leading to each dormitory. Calls to the Abuse Hotline are documented in the program logbook.	
Youth were informed of the Abuse and Contact Number (see youth survey results)	X					Youth are given a copy of the youth handbook during orientation which includes the abuse hotline information. Four youth surveyed indicated knowledge of the abuse hotline and location of hotline number in the facility.	
Management takes immediate action to address any incidents of threats or abuse			X			Per Chief Operating Officer (COO), no management disciplinary actions have been taken against staff for excessive use of force or physical/verbal abuse toward youth.	
Grievance Process							
Agency has a formal grievance process	X					The agency has a grievance policy 1.02.01 that was approved by the interim executive director on 5/15/22.	
Locked box accessible to only management and available to youth in a common area	X					During the facility tour, a locked grievance box was observed to be mounted on wall adjacent to the dayroom with accessible grievance forms. The key for the grievance box is accessible to only the shelter manager and clinical supervisor.	

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					Per the shelter manager, direct care workers do not handle the complaints/grievance documents. The clinical supervisor is responsible for collecting and resolving grievances submitted by youth.	
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			Agency has no documentation of grievances prior to the former QI manager's departure in September 2021. The shelter manager indicated no written grievances have been reported since that time.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						**YES** If NO, explain here: The agency has the required policy and procedure 1.03 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		
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 total of twelve CCC calls were reported by the program during the past six months. Four of the incidents were absconds, two medical, three contraband, two program disruption, and one youth behavior. The shelter manager became aware of a reportable incident during the QI review of bed checks on 5/25/22 where staff falsified bed checks. The incident was reported on 5/26/22 to CCC beyond the two hour window required.	Exception: Three of the twelve reportable incidents during the review period were reported to CCC outside the required 2-hour timeframe.
The program completes follow-up communication tasks/special instructions as required by the CCC	X					Updates and follow-ups were documented and reported on all applicable incidents as requested by CCC.	
Incidents are documented in the program logs and on incident reporting forms		X				Eleven of the twelve CCC incidents were completed on the program's incident reporting form and eight were documented in the logbook.	Exception: One of the 12 CCC reports (11/26/21) was not found to be documented on the agency's incident reporting form. Four CCC incidents dated 3/29/22, 4/19/22, and two on 5/2/22 were not documented in the program's logbook.
All incident reports are reviewed and signed by program supervisors/directors	X					All twelve incident report forms were reviewed are signed by program supervisor or director.	
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						**YES** If NO, explain here: The agency has the required policy and procedure 1.04 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		

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				Three first year direct care staff training files were reviewed. Two of the three completed the DOJ Civil Rights training within 30 days of hire.	Exception: One of three first staff hired 10/18/21 did not complete the civil rights training during the required 30-day time frame.
All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				Three first year direct care staff training files were reviewed. All three staff were missing some of the required training due during the first 90 days. The provider submitted a Master Cardio Pulmonary Resuscitation (CPR) and First Aid (FA) roster listing names of staff and dates the training was completed; however, valid certificates were not in all of the files reviewed. A master staff list of Florida Network Bridge training was also reviewed for required training completed by the three staff.	Exception: None of the three first year staff completed all mandatory training required during the first 90 days. One staff is missing orientation, behavior management, child abuse, and medication distribution training. There was no CPR/FA certificate in the file. A second staff is missing orientation, behavior management, child abuse, SkillPro Suicide Awareness, and medication distribution training. There was also no CPR/FA certificate in the file. The third staff is missing orientation, behavior management, and medication distribution training.
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			The program did not have any new non-licensed mental health clinical shelter staff hired during the review period.	
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			No applicable staff.	
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				Three in-service staff training files reviewed show staff completed the 40 hours required annually. However, two of the three in-service staff did not complete all annual required training topics or within the timeframes required.	Exception: Two of the three in-service staff did not complete all mandatory annual trainings as required. One staff did not complete two biannual and two annual DJJ SkillPro trainings on time. They were completed in 2022 but were not done in 2020 or 2021, respectively. The same staff completed human trafficking and child abuse training late (last done 3/4/21) and was missing Managing Aggressive Behavior training. A second staff completed DJJ SkillPro suicide prevention, human trafficking and child abuse training after the due dates (previously done in 2020-2021 training year, not 2021-2022 year).
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				The program consolidates all staff training transcripts alphabetically in a binder. Each staff's training is documented on a training log that lists the dates, topics, and hours completed.	Exception: Supporting training documentation was not consistently present for all training completed. Some training records were missing DJJ SkillPro transcripts, Florida Network Bridge transcripts, or certificates for MAB and/or CPR/First Aid.
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES** If NO, explain here: The agency has the required policy and procedure 1.06 that was approved May 15, 2022 by the interim executive director.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					Driving records are checked by the insurance company once the staff is identified by the program as an authorized driver. Driving records are also checked by the Florida Department of Highway Safety and Motor Vehicles (FLHSMV) yearly for all authorized drivers.	
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 35 approved drivers who have a valid driver license and is insured under the program's automobile insurance policy.	
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					Per the agency's transportation policy, 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 one 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					Three single transports were reviewed for the review period. Approvals were documented in the logbook for each transport indicating supervisor was aware and approved single transport.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					Third party present for all non-single transports reviewed were 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				The program documents transports in the logbook.	Exception: Transportation entries typically include names of staff and youth and occasionally, intended destination and mileage; however, staff do not consistently include mileage, purpose of travel, and location as required.
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.	
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 total of four residential files (2 closed, 2 open) and four community counseling files (2 closed, 2 open) were reviewed. Four applicable residential records reviewed were found to have NIRVANA assessments completed within 72 hours of admission.	
Non-Residential youth: NIRVANA is done within 2 to 3 face-to-face contacts after the initial intake	X					Four community counselling youth records were reviewed. The NIRVANA/needs assessment was completed within 2 to 3 face-to-face contacts in all four applicable records.	
NIRVANA is conducted by a bachelor's or master's level staff member	X					All eight assessments were conducted by a bachelor's or master's level staff member.	

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				The supervisor's signature was present on seven of the eight NIRVANA/needs assessments reviewed. One of the NIRVANA assessments reviewed did not contain the staff and supervisory signatures.	Exception: Nirvana assessment completed 4/14/2022 did not contain the staff and supervisory signatures, The staff and supervisor provided a late entry signature to the assessment form upon notification during the QI review.
Shelter Youth: The NIRVANA Self-Report (NSR) is completed within 24 hours of youth being admitted into shelter.	X					There were four applicable youth residential records and four community counseling records reviewed. Three of the eight records reviewed were applicable and 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			None of the four closed youth records met the criteria for the NIRVANA re-assessment.	
A NIRVANA Re-Assessment is completed every 90 days with the exception of SNAP services.			X			None of the youth records reviewed met the re-assessment criteria.	
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					One of the eight youth records reviewed was applicable. The youth was referred to Banyan Health System for assessment due to the identified elevated risk of suicide.	
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					Proof of a completed Assessment of Suicide Risk, conducted by a licensed professional, was observed in the youth record.	
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.	
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					There were four residential and four community counseling youth records reviewed. Service plans were developed timely in seven of the eight records reviewed. One of community counseling records was not applicable. The service plan was not completed as youth was discharged due to turning 18 years of age, prior to the completion of the service plan.	
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					Youth signatures were not present in three of the eight records reviewed and parent/guardian signatures were missing in six of the eight records; however, the case notes clearly indicated the parent/youth participated and provided virtual or telephone approval as the youth and parent attended remotely due to COVID-19 and therefore not physically present to sign the service plans.	
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	X					Five of the eight records reviewed were applicable and supported case/service plans are reviewed for progress every 30 days.	
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 May 15, 2022 by the interim executive director.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Counselor/Case Manager is assigned	X					A total of four residential files (2 closed, 2 open) and four community counseling files (2 closed, 2 open) were reviewed. Each of the eight records reviewed showed a counselor was assigned to the youth.	

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					All eight records reviewed demonstrated applicable case management services were provided as needed and progress is monitored. Referral, service plan implementation, monitoring of progress, and family support was observed in each of the records. Follow-ups after 30 and 60 days of exit were observed in all of the four applicable closed records reviewed.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	X					Include examples of written agreements with community partners:	
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.	
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					There were four residential records and four community counseling records reviewed. Seven of the eight records were applicable and demonstrated individual and/or family counseling was offered. One youth was not applicable for counseling services.	

Shelter Program							
Shelter programs provides individual and family counseling		X				Service plans maintained demonstrate all seven applicable youth were listed as needing individual and/or family counseling services as identified during the assessment.	Exception: One youth's service plan identified individual counseling as part of the youth's goal; however, there were no progress notes or case notes indicating counseling services were provided.
Group counseling sessions held a minimum of five days per week		X				The program is required to provide group sessions at least five days a week; however, some group sessions were not fully documented, did not include the topics, or clearly identify the subject on the group logs and did not meet the criteria for groups. In review of the past six months sign-in logs, it was observed groups were not being conducted consistently at least five-days a week, as required.	Exception: Group counseling is to be provided at least 5 days a week. However, group logs reviewed showed groups not being conducted consistently 5 days a week, as required.
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					Review of the group schedule and group sign-in logs for December – May 2022 was conducted. Sign-in logs showed groups that were conducted were held a minimum of 30 minutes and above. Groups consisted of a variety of facilitators, clinical staff, and other staff members. Group topics varied in different subjects relevant to informational, developmental, and/or educational, to provide opportunity for youth engagement.	
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					Verified in three of the four applicable community counseling records reviewed. Community based services were provided to keep families intact and minimize out-of-home placement. One youth was not applicable due to age and being discharged prior to services being put in place.	
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					Coordination of services was observed in all eight records reviewed.	

Maintain individual case files on all youth and adhere to all laws regarding confidentiality	X					All youth records are entered and maintained electronically in the Lauris Online system. An individual youth record is on file for all eight youth files reviewed.	
Case notes maintained for all counseling services provided and documents youth's progress	X					Legible case notes are maintained in Lauris Online and individual records are validated for each youth.	
On-going internal process that ensures clinical reviews of case records and staff performance	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. All eight records reviewed were signed by the supervisor and/or licensed professional.	
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 and procedure 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			No case staffings were held at the Homestead location since the last QI review.	
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			No eligible practice.	
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	X					The program has a case staffing committee that consists of a representative from the local school district and DJJ representative/CINS-FINS provider.	
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					Other participants are invited to attend case staffing meetings and may include a substance abuse or mental health representative as needed.	
The program has an established case staffing committee, and has regular communication with committee members	X					The program communicates with the case staffing committee via email whenever a meeting is scheduled.	

The program has an internal procedure for the case staffing process, including a schedule for committee meetings	X					The procedures are outlined in policy 2.06.	
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services			X			No practice to review as there were no case staffings for Homestead since the last QI review.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations			X			N/A	
If applicable, the program works with the circuit court for judicial intervention for the youth/family			X			N/A	
Case Manager/Counselor completes a review summary prior to the court hearing			X			N/A	
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.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Facility Inspection		X				Date of facility inspection(s) reviewed: May 25-26, 2022 During the facility walk through all furnishings were in good repair. There were several cushions missing in the sofas located in the dayroom. The facility was free of insect infestation, grounds were landscaped and maintained well. The exterior area was free of debris and hazards and all doors to staff and agency vehicles were locked and secure. Agency vehicles were equipped with all major safety equipment. The program has dormitory style rooming and both the boys and girls dorm rooms were well maintained, did not contain contraband, and were free from graffiti. Each youth had an individual bed with clean linens. Youth also has lockable place to keep personal belongings.	Exception: The dumpster was uncovered on both days of the review.
Additional Facility Inspection Narrative (if applicable)	There were egress plans positioned in the shelter immediately outside both boys and girls dorms. Grievance box is located in the day room and is accessible to all youth. Abuse hotline and DJJ notice was also posted and accessible to youth. Lighting is adequate for tasks performed in shelter. Key access to the shelter is limited to staff members. DCF childcare license for 20 beds that expires February 28, 2023 was displayed in the facility. Chemicals were also locked in a chemical closet with accompanying MSDS forms. Inventory for chemicals is also completed at least once per week. Agency has all related health inspection forms needed and foods were properly marked and labeled in the fridge. The fridge temperature was 40 degrees Fahrenheit and freezer temperature was 2 degrees Fahrenheit.						
Fire and Safety Health Hazards		X					

Additional Fire and Safety Health Hazards Narrative (if applicable)	The annual facility fire inspection was conducted by Miami Dade Fire Rescue Department on 5/10/22 and the facility is in compliance with local fire safety guidelines. Fire Drill records were reviewed for January, March and May of 2022. In January, 3 drills were completed within 2 minutes or less. In March 2022, 2 drills were completed within 2 minutes or less. In May, 2 drills were completed in 2 minutes or less. All annual fire safety equipment and inspections are valid and up to date. There was one emergency drill completed from January 2022- March 2022. This occurred on February 02.04.2022.						Exceptions: In January of 2022, two of the three fire drills that were completed were missing signatures. There were no Emergency Drills completed from October 2021 - December 2021, nor in January or March 2022.
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**				According to the schedule, at least one hour of physical activity is provided daily and youth are provided the chance to engage in different faith-based activities. Youth have opportunities to complete homework and access books for reading. The daily schedule is posted in the dayroom and is accessible to all youth and staff to review.	Exception: While home during school hours youth were not observed to be consistently actively engaged in meaningful, structured activity. Youth were observed watching TV, eating and sitting in front of games during school hours. Often staff were attending to administrative tasks and were not able to fully engage youth in a meaningful way during school hours. On the second shift there were more staff onsite and the level of engaging youth in meaningful activities increased.

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.	
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 program utilizes the Note Active electronic logbook as it's system of record for daily activities. A random selection of logbook entries were reviewed for the following dates: November 15-28, 2021; December 13-19, 2021; January 3-9, 2022; January 17-23, 2022; February 7-13, 2022; February 21-27, 2022; March 14-27, 2022; April 4-10, 2022; April 21-27, 2022; May 2-8, 2022; and May 16-22, 2022.	Exception: Reviewer observed inconsistency with highlighting logbook entries regarding sight and sound alerts. Sight and sound alerts were not highlighted in the logbook on November 6,7,8,10,12; January 8,9,10,16,17; February 14th; and May 14th.
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					The E-logbook makes all of the entries legible. Program entries are brief and information-based. Use of the E-logbook afford the program the ability to have all entries date and time stamped. Additionally, all program staff have individual login information for identification of the entries.	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	X					The E-logbook has a strike through feature which the program has utilized when appropriate. Errors made in logbook entries reviewed between November 5th, 2021 until May 26th, 2022 shows errors crossed with a single line and initials of staff making this entry in the logbook.	

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				Reviews of the program's logbook was conducted to establish supervisory reviews are conducted every week as required.	Exception: Director or designee does not review the logbook every week and make chronological notes in the logbook indicating dates reviewed. This indicator received a Limited rating during the last QI review for a similar finding. There were no weekly reviews for the vast majority of the review period from November 5th until December 20th; December 29th until March 13th; May 28th until April 5th. After periods mentioned, there were weekly reviews found until May 25th.
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				During the review period, there was no clear evidence of staff reviewing the logbook at the beginning of each shift and documenting accordingly.	Exception: Although there is a staff per shift who stated to have reviewed logbook, not all staff scheduled are indicating they have reviewed the logbook. Also, there are gaps on logbook review by staff between November 5th and May 25th.
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					From November 5th until May 26 Director and supervisor have made reviews on logbook upon entrance from the last two prior shifts.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	X					Resident counts are documented in the logbook by listing first name of youth present during various activities including transportation, visitation, and home visits. Youth movement occurred frequently between the two Miami Bridge locations and were documented in the respective program logbook; consequently, logbook entries from both locations had to be reviewed to account for youth movement and supervision.	
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.	

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					This facility has behavior management strategies that are clearly identified in the consumer handbook, posted throughout the program, and given to youth at intake.	
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 program uses a point system to manage behaviors. The system provides youth with an opportunity to earn points for complying with program expectations or to lose point for infractions. The point system serves to classify each youth's behavior instead of a group. Interventions are applied immediately and reflect the severity of the behavior. Only staff disciplines youth and youth are not denied basic rights as punishment. The BMS includes an incentive program where youth can use their points earned to purchase items. According to the shelter manager, all supervisors are trained on BMS and staff receive training in managing aggressive behavior to utilize verbal intervention and de-escalation techniques.	
Program's Use of the BMS							

All staff are trained in the theory and practice of administering BMS rewards and consequences		X				Training records for three first year direct care staff were reviewed. BMS training is listed as a required training but there was no evidence staff received the training.	Exception: None of the training records reviewed for the three first year staff supported staff received BMS training.
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	X					Program supervisor monitors point cards to evaluate and provide feedback to staff during staff meetings on use of behavior management system and on youth engagement.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	X					All supervisors at this facility have been trained to monitor the use of rewards and consequences by their 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.	
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				Reviewed staff schedules for the past six months as well as transportation schedules during the same period. Staff schedules revealed the program maintained a minimum staffing ratio of 1:6 during wake hours and 1:12 during sleep period.	Exception: Transportation with youth was not found to be within ratio on February 17, 2022 where one staff was noted as transporting 8 youth.
All shifts must always provide a minimum of two staff present	X					The program schedules from November 2021 - May 2022 show a minimum of two staff scheduled per shift. Adequate staff coverage was observed on the overnight bed check video dates randomly selected and reviewed below.	
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					Per interview with program manager, all staff working with youth are background screened and receive adequate training including job shadowing prior to working directly with youth.	

The staff schedule is provided to staff or posted in a place visible to staff	X					Staff schedule is posted inside staff office, which is visible to all coming into the shift.	
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					There is an on-call schedule next to staff schedule in case an emergency occurs and facility needs coverage by the on-call staff.	
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				Review of video surveillance and bed checks was conducted for the following randomly selected dates/times: April 24th, 12-2 a.m.; April 30th, 2-4 am; May 4th, 4-6 am; May 13th, 1-3 am; and May 17th, 3-5 a.m. Some of the checks done on April 24th and 30th on girl's hallway did not occur as noted in the logbook. All girls at this facility share a large dorm room on a wing on the opposite side of the facility from the boy's dorm. In order to do bed check, staff has to go down the hallway and enter each dorm room. Therefore, when the staff does checks in the boys or girl's dorm, he/she is out of video sight for a brief moment.	Exception: On April 24th between 12:15-2:00 a.m.,15-minute bed checks did not occur on the girl's dorm. Also, on April 30th between 2:00 am and 3:00 a.m., 15-minute bed checks were skipped. Staff is seen on the video in both instances going down the hallway and scanning the barcode to indicate completing bed checks. At no instance did the staff go inside the girl's dorm yet staff recorded bed checks as completed in the logbook. This indicator was rated Limited during the last full QI review.
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						**YES** If NO, explain here:	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**	The agency has the required policy and procedure 3.08 that was approved May 15, 2022 by the interim executive director.	
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					There is a notice visibly posted in the facility indicating it is under surveillance. Facility's video surveillance can store at a minimum 30 days of video. Video system records, date, time and location. The video is connected to the generator which activates if facility loses power. There are a total of 32 cameras, 16 for the outside areas and 16 on the interior of the facility. Cameras are not inside youth bathrooms or bedrooms.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	X					Agency staff authorized to have access to the cameras includes the chief operations officer and shelter director from Central and Homestead facilities.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.		X				The shelter program manager was interviewed to ascertain practice of conducting supervisory video reviews.	Exception: Video reviews have not been conducted at least once every 14 days between November 2021 and March 2022. Moreover, video reviews were irregularly conducted between March 14 to March 29; March 31 to April 19; and May 2nd to May 26.
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	X					Facility has adequate cameras that capture daily activities. The few reviews conducted by the program manager included a random sample of overnight shifts.	
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					Director provided an email report which indicated the video system is used when investigating incidents. Policy 3.07 indicates that third party review can be made available during investigations and in conjunction with specific incidents.□	

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			Staff communicates with program manager if there is an issue with the video surveillance. The program manager then contacts the chief operations officer who is responsible for scheduling repair calls. No camera service order requests were made during the review period.	
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.	
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				Five closed files were reviewed for this indicator. All files had the suicide risk screening which occurred during the initial intake and screening process.	Exception: Four of five 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 program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services.	
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					Five closed files were reviewed and in all files youth 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					Five closed files were reviewed and in all files a staff person was assigned to monitor youth documented youth's behavior.	

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				Five closed 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. As a result, the agency contracts with a third party, Banyan Heath Systems, to provide services needed from a licensed professional. None of the five youth records demonstrated suicide supervision level changes were authorized by a licensed professional.	Exception: The agency is required to provide a licensed professionsalto oversee the status of all youth deemed at risk for suicide and susequently placed on elevated supervision. There was no evidence that Banyan staff contracted to provide services professionally are licensed or background screened. When evidence was requested from the company to verify licensure of all staff, none was provided. Consequently, services to be provided by a licensed professional, as required by the indicator, could not be validated. The CEO and COO of Florida Network of Youth and Family Services were informed Bayan declined the request for information to verify the clinical credientials of its on-call staff dispatched to program to assess status of youth placed on elevated supervision.

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.	
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 Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management. The oral medications are stored separately from injectable epi-pen and topical medications. There were no medications requiring refrigeration at the time of the review. However, there was a secure refrigerator where they could be stored when needed that is used only for this purpose. Temperature was at a range of 36-46 degrees. Narcotics and controlled medications are stored in the Med-Station. The agency does have required Pyxis keys and they are accessible to staff in the event they need to access medications.	Exception: Topical Medications are not stored in Pyxis. They are stored in the intake room behind two locks. Discrepancies were reviewed from 2/1/2022- 5/26/22.

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				The agency maintains a minimum of 2 Super Users for the Med-Station and staff designated User Permissions have access to secured medications, with limited access to controlled substances. There is a Medication Distribution Log that is used for distribution of medication by non-licensed and licensed staff. The agency verifies medication using one of the methods listed in the FNYFS Operations Manual. The delivery process of medication is consistent with the FNYFS Medication Management and Distribution Policy and the agency does not accept youth currently prescribed injectable medications, except for EpiPens.	Exception: There is no evidence of training records that reflect all medication trained staff have been trained in the use of an EpiPen. When nurse is on duty, medication processes are not consistently conducted by the nurse as the RN has a dual role of RN and Shelter Director.
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					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. Over-the-counter medications are inventoried at minimum on a weekly basis. Sharps (nail clippers) are secured, and counted and documented at minimum weekly.	

There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	X					There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	
Medication discrepancies are cleared after each shift.		X				Discrepancies were reviewed from 2/1/2022- 5/26/22. Six of ten discrepancies were resolved on the same shift.	Exception: Four of ten discrepancies were resolved after the shift was completed.
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.	
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				Four closed files were reviewed for this indicator. In each file, all youth received off-site emergency medical care. In two of four files, an incident report was submitted. There is verification receipt of medical clearance via discharge instructions for all four youth upon return to the shelter.	Exception: An incident report was not reported to CCC for two of four offsite medical emergency incidents.
All staff are trained on emergency medical procedures	X					All staff are trained on emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	X					Program has several Knife-for-Life's that are located in both vans as well as the staff office.	
First aid kit/supplies are fully equipped and inventoried	X					First aid kits are located and inventoried in both vans and in the staff office.	