Florida Network for Youth and Family Services
Compliance Monitoring Report for

LUTHERAN SERVICES FLORIDA – MIAMI BRIDGE (CENTRAL)

2810 NW South River Drive
Miami, Fl. 33125

December 6-7, 2023

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for Lutheran Services Florida Miami Bridge (LSF Miami Bridge) Central for the FY 2023-2024 at its program office located at 2810 NW South River Drive, Miami. 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. LSF 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 from July 2023 through June 30, 2024.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC, and Peer Reviewers. Agency representatives from LSF Miami Bridge Central present for the entrance interview were: Jose Fontanez, Program Director; Ashley Wooten, Clinical Director; Sabrina Valentin, Shelter Manager Central; Samantha Roberts, Shelter Manager Homestead; C.J. Fernandez, QA Management Specialist; Tracy Scott, Registered Nurse; and Lashonda Chavis, Intake Coordinator. The last onsite QI visit was conducted December 8, 2022.

In general, the Reviewer found that LSF Miami Bridge Central is in compliance with specific contract requirements. **LSF Miami Bridge Central received an overall compliance rating of 100% for achieving full compliance with 12 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

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 12-06-2023-2024

Agency Name: Lutheran Services Florida Miami Bridge (Central)	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 2810 NW South River Drive, Miami, Fl 33125**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): December 6-7, 2023**

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:
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.	☐	☐	☒	☐	☐	Documentation: Peer training list. The agency currently has four staff members certified as DJJ QI Peer reviewers: Lashonda Chavis, Citizen Fernandez, Jose Ortega, and Ashley Wooten. To date, none of the staff has participated in a QI review but will be scheduled to participate in the FY23-24.	
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 a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: Grant Listing FY23-24. The agency provided a list of five additional contracts for FY2023-2024. The list includes: the name of grant, funding source, contract period, and contract amount.	
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	☐	☐	☐	☒	☐	Documentation – LSF Certificate of Insurance. General Liability through Markel Global Reinsurance Company, for limits of coverage of $1,000,000 each $3,000,000 aggregate, and medical expense for $10,000, effective 6/01/2023 – 6/01/2024.	

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$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**						Automobile insurance through Florida Insurance Trust for combined single limits for $1,000,000 each accident, effective 6/01/2023 – 6/01/2024. Workers Compensation through Accident Fund Insurance Company of America with limits of $1,000,000 each/aggregate, effective 6/01/2023 – 6/01/2024. Umbrella liability through Century Surety Company with limits of $1,000,000 each/aggregate, effective 6/01/2023 – 6/01/2024. Professional Liability Abuse and Molestation through Markel Global Reinsurance Company for $1,000,000 each and $3,000,000 aggregate, effective 6/01/2023 – 6/01/2024. Florida Network is listed as certificate holder	

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External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	Interview: During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source	
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: Accounting Procedures Manual. Agency maintains an Accounting Procedures Manual that is consistent with GAAP and provides for limited internal controls. The fiscal manual is updated as necessary with revised policies showing a revision/approval date. The most current approval date is October 5,2022. Policies are approved by the Chief Financial Officer.	
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: GL Detail Miami CINS/FINS YTD October 2023. The agency maintains a detailed general ledger with corresponding source documents. The General Ledger documents and tracks CINS/FINS funding separately from other funding sources by category.	

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						Program code 3100 is designated for Miami Bridge and each transaction is further delineated by program location, Miami, or Homestead.	
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**	☐	☐	☒	☐	☐	Observation/Documentation: Reviewed petty cash Policy and Procedure 4.32 included in section 4 of the Fiscal Manual that was last approved October 5, 2022. The program has a petty cash fund that is used for the shelter. The shelter manager is the custodian of the petty cash which is maintained in a locked box in the manager's office. Petty Cash Custodians request reimbursement of their funds by submitting a Petty Cash Reconciliation Request that includes all original receipts for which reimbursement is being requested along with the detail transaction form and summary form completed. Petty Cash reconciliations are completed each month or as needed to maintain an adequate fund on hand and at the end of each fiscal and contract year.	

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d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation: Reviewed Bank Statements Ameris Bank operating account and the corresponding bank reconciliations for the period May-October 2023. Bank reconciliations are processed by the finance department in the Tampa Corporate office. Successful bank reconciliations were conducted within 2 weeks of receipt of bank statements. All of the reconciliation worksheets were reviewed by a second party in addition to the preparer. Vendor payments are distributed through the corporate office in Tampa, Florida through check requisitions by the Broward office. Vendor files are maintained locally with copies of the invoices and check requisitions.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag.	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS funds since the last time on-site.	

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In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. **PTV/ON SITE**							
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Tax Recap 1st and 2nd quarter. ADP is contracted by LSF to process payroll. ADP is responsible for submitting information for W2s, Quarterly 941 reports, and payroll taxes. Tax Recap Ledger Deposit Details for the first and second quarters of 2023 were reviewed. These reports demonstrate submission of payroll taxes be or before the due dates.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided Budget vs. Actual report for the Miami Bridge CINS/FINS Program #304 for the period June through October 31, 2023. A review of the report was conducted, and variances are monitored on a monthly as well as year-to-date basis with management and the Finance Committee.	

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h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Can obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: The provider submitted a copy of the Financial audit conducted for year ending June 30, 2022 for the review. The audit was completed by RSM US, LLP and was dated December 22, 2022. Per the auditors, there was no management letter or deficiency control letter issued as there were no matters required to be reported in these letters.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation reviewed included policy and procedures regarding the following: data back-up contained in the Agency's Policy and Procedure Section 2.10, on Information Management; Section 1, 1.09 Confidentiality of Client Information; 11.09 IT Security; Section 12, 12.01 Access to Case Records; 12.02 Case Record Keeping; 12.07 Risk Prevention and Management; 19.01.27 HIPAA; and 19.03.05 Security of Data and Information Technology.	

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j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least $19.00 per hour. This also includes funding for additional staff as approved by the Department. **ON SITE**	☐	☐	☒	☐	☐	Interview and documentation; A review of offer letters, and employee personnel action forms was conducted with the Senior Administrative Assistant to validate all direct care staff is paid at least $19 per hour.	

CONCLUSION

LSF Miami Bridge Central has met the requirements for the CINS/FINS contract as a result of full compliance with 12 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the 12 indicators were not applicable because: 1) the agency does not have any corrective action item(s) cited by an external funding source, and 2) no equipment has been purchased with FNYFS funds. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited or recommendations made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, all the indicators reviewed were carried out in a manner which meets the standard 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.

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of LSF Miami Bridge - Central Miami Residential Program

December 6-7, 2023

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 100 %
Percent of indicators rated Limited: 0 %
Percent of indicators rated Failed: 0 %

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Special Populations	Satisfactory
2.09 Stop Now and Plan (SNAP)	Not Applicable

Percent of indicators rated Satisfactory: 100 %
Percent of indicators rated Limited: 0 %
Percent of indicators rated Failed: 0 %

Standard 3: Shelter Care & Special Populations

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

Percent of indicators rated Satisfactory: 85.71 %
Percent of indicators rated Limited: 14.29 %
Percent of indicators rated Failed: 0 %

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 92.86 %
Percent of indicators rated Limited: 7.14 %
Percent of indicators rated Failed: 0 %

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/Florida Network of Youth and Family Services
Yvrose Sylvain – Regional Monitor, Department of Juvenile Justice
Karen Martinez – Florida Keys Children Shelter
Ivonne Medrano– Prevention Central
Krizia Santana – Center for Family and Child Enrichment

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 July 1, 2023).

Persons Interviewed

	Chief Executive Officer	X	Case Manager	X	Nurse – Full time
	Chief Financial Officer		Counselor Non-Licensed		Nurse – Part time
	Chief Operating Officer		Advocate	1	# Case Managers
	Executive Director	X	Direct – Care Full time	1	# Program Supervisors
X	Program Director		Direct – Part time		# Food Service Personnel
X	Program Manager		Direct – Care On-Call		# Healthcare Staff
X	Program Coordinator		Intern		# Maintenance Personnel
X	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	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	5	# Health Records
X	Logbooks		Key Control Log	6	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	8	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
X	Contract Scope of Services	X	Precautionary Observation Logs	6	# 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
	Program Activities	X	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		Staff Interactions with Youth	X	Census Board

Surveys

1	# of Youth	9	# of Direct Staff		# of Other		

Comments

A Quality Improvement Program Review was conducted for FY 2023-2024.

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

On July 2, 2022, Lutheran Services Florida (LSF) entered into a management service agreement with Miami Bridge Youth and Family Services to operate the Child in Need of Services and Family in Need of Services (CINS/FINS) program in two locations, Miami Bridge Central Shelter (MB Central) located in North Miami and a south shelter located in Homestead, Florida. The merger is called LSF Miami Bridge and under this agreement, the agency will continue to provide services to serve both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abused, 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 accredited by the Council of Accreditation (COA) through August 31, 2025. In the future, Miami Bridge will be integrated into LSF's re-accreditation timeline of February 28, 2026. The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards. The facility is also licensed through the Department of Children and Families for 20 beds and the current license is effective 6/1/2023.

The last QI review conducted for LSF Miami Bridge Central was December 8, 2022. The shelter was closed at the beginning of the LSF/Miami Bridge partnership pending completion of construction and briefly reopened for admissions in June 2023. Due to continued construction, staff turnover, and staff shortage, the agency transferred current youth to its Homestead location on November 17th; however the shelter remained open for intakes with the expectation to operate at full capacity again by January 2024. There were no youth in the shelter during the annual QI review.

The following programmatic updates were provided by the agency:

Staffing

Throughout the recent assessment period, guided by the Program Director, Jose Fontanez, the CINS/FINS operations have maintained stability, welcoming additional staff to reinforce an efficient programmatic framework. Mr. Fontanez, currently a registered mental health counselor in the state of Florida, has also enhanced the program by offering supplementary mental health guidance.

In her capacity as Clinical Director, Ashley Wooten, a licensed clinical social worker, plays a crucial role in upholding the quality standards of therapeutic aspects within the residential and community counseling programs. Her experience and knowledge have contributed to sustaining the effectiveness of these programs. Through her diligence and leadership, she actively supports various key functions in the operations of the programs. Unfortunately, as of the writing of this update, Ms. Wooten has submitted her resignation and will be transitioning away from the agency as of December 15, 2023.

Lashonda Chavis heads the intake and admissions department of the program, overseeing both residential and non-residential aspects. Her dedication to supporting youth and families, coupled with her strong organizational skills, has played a crucial role in advancing the sustainability and expansion of Miami Bridge.

In January 2023, Samantha Roberts made the transition from her previous position at an LSF residential program in Sarasota, Florida, to assume the role of Homestead Shelter Manager at Miami Bridge. In May of 2023, she then became the shelter manager for the Central location. She brings forth consistent and transformative leadership, elevating the overall work environment and improving the quality of services provided to shelter beneficiaries.

Sabrina Valentin joined the team in May 2023. Ms. Valentin has extensive experience in the child welfare system as she previously worked with a dependency referral agency. As a dedicated shelter manager specializing in youth and families, she leads with a compassionate and inclusive approach. With a focus on creating a safe and supportive environment, Ms. Valentin implements strategies to address the unique needs of individuals and families seeking help. Known for her adept organizational skills and collaborative spirit, she plays a pivotal role in fostering a sense of stability and hope for those navigating challenging circumstances.

Citizen Jane Fernandez continues the position of Quality Management Specialist. Ms. Fernandez remains responsible for overseeing the development and maintenance of quality programs, systems, processes, and procedures. Her role ensures compliance with policies, and she strives to uphold established internal and external standards and guidelines, emphasizing the performance and quality of services.

Tracy Scott remains as the in-house registered nurse, providing exceptional medical support to the population served and offering medical training to the staff. His main responsibilities include treating and caring for the youth in the program, as well as providing information on treatment procedures and overall care. Tracy divides his time equally between both sites dedicating 20 hours per week to each.

Rosie Soroka, continues the role of Residential Counselor since February 2023. Rosie's dedication to making a positive impact in the lives of youth, coupled with her extensive experience in working with them, has greatly benefited the program. She specializes in mental health services, offering therapeutic care to both the youth and families in our residential program.

Genesis del Castillo, a residential counselor began her employment with the agency in August 2023 and brings much experience to the role with several years working intimately with children and families. Her background reflects a commitment to fostering a supportive and nurturing environment for those under her care. With a nuanced understanding of the unique challenges faced by children and families, she employs a compassionate and skillful approach to ensure the well-being and positive development of those they serve.

Amanda Lopez is the third residential counselor who arrived in September 2023. Having worked with the agency as an intern, the decision was made to offer her full-time employment due to her ability to create individualized strategies tailored to the diverse needs of each child and family. Her understanding of behavioral dynamics and effective therapeutic interventions has consistently contributed to successful outcomes and strengthened family bonds. Known for her empathetic communication style and adept problem-solving skills, she remains a trusted and valued member of the team, making a lasting impact on the lives of those in their care.

The agency added two case managers, one for each shelter. These employees are Latoya Blair and Karina Bonilla. Case managers dedicated to youth and families play a pivotal role in the organization, serving as the primary point of contact and support for clients. With a comprehensive understanding of the unique challenges faced by each family, these professionals collaborate closely with various stakeholders to develop and implement tailored intervention plans. Through their compassionate guidance and advocacy, the case managers empower youth and families to navigate complex situations, ensuring access to essential resources and fostering positive outcomes.

Under the guidance of the clinical director, the community counseling services are overseen by a team of six counselors. At this time, only four community counselors are employed with Miami Bridge: Jose Ortega, Brianny Hernandez, Jeanette Wright, and newly added Bernadette Chandler. There is an applicant that has accepted an initial offer and is in the onboarding process leaving only one vacant position within the community counseling team, and efforts are underway to actively recruit a suitable candidate. The community counseling program has fostered a robust partnership with Miami-Dade County public schools, particularly in handling truancy referrals.

At present, there are 16 Youth Care Specialists serving as direct-care staff, playing a pivotal role in supervising residents, providing quality care, ensuring a safe environment, and accompanying residents on outside activities. In anticipation of accepting referrals again at the Central location, the program aims to augment this staff by hiring approximately 24 individuals, enabling it to operate at full capacity at both locations. To enhance the residential counseling component, the agency is planning to recruit one additional master's level clinicians.

Program Updates

The program offices have not changed since the last QI visit. The administrative office is located at 2810 NW South River Drive, Miami, Fl. 33125. LSF Miami Bridge serves Miami Dade County through two sites located at 1) 2810 NW South River Drive, Miami, and 2) 326 NW 3 Ave., Homestead. Both sites are licensed to serve twenty (20) residential youth and the licenses were renewed by the Department of Children and Families (DCF) on April 1, 2023 (Homestead) and June 1, 2023 (Central). The residential program serves youth between the ages of 10-17 while the community counseling program serves ages 6-17.

The service practice model is diverse in that services are provided based on the needs of the individual or family. The residential program offers in-person services and when necessary/requested, family sessions can be offered virtually. The community counseling program offers in-person, virtual, and home-visits. All files are stored electronically. The program recently implemented the Journey to Success Behavior Management System. Staff attended the six hours foundations and implementation training in May 2023.

Facility

The central facility has completed its' kitchen renovation and was approved to open in June 2023. It is also in the planning stages of converting its dorms to semi-private rooms. Target date for dorm completion is the end of 2023 beginning of 2024. The agency is currently working with City of Miami, Miami-Dade County, and the city of Homestead to transfer all property leases to Lutheran Services of Florida from Miami Bridge.

Funding/Finance

The agency received award confirmation from The Children's Trust of Miami-Dade County to fund an agriculture/culinary summer program for both residential and non-residential clients to begin the summer of 2024. A capital campaign is ongoing. No new assets have been acquired. Current funding sources include the United Way, Florida Network Youth and Family Services, Department of Children and Families, and private donations. All contracts have been retained and are in full effect.

Governance and Community

Currently, Miami Bridge's board structure will remain the same until funding through the Community Development Block Grant (CDBG), earmarked for construction of the boy's dorm, is utilized. Upon utilization of the funding, the agency Miami Bridge will be fully acquired by Lutheran Services of Florida. Community engagements have included over 40 events during the current contract year.

Major Challenges

During the current review period, the program has experienced challenges in successfully recruiting additional Youth Care Specialists. In addition, some Youth Care Specialists' who transferred to LSF from Miami Bridge, have decided to resign. These challenges have resulted in merging the youth in Central back into the Homestead site as of November 2023, while temporarily halting referrals to the Central shelter. Due to this, LSF recruiting department has committed several people to assist in the recruitment process. The recruitment process has successfully produced over 24 new applicants who have and will be starting employment in December 2023. The goal is to reopen the Central shelter in January 2024.

Narrative Summary

LSF Miami Bridge (Central) is under the leadership of a management team, including a program director, a shelter director, a licensed clinical director, a quality management specialist, an intake coordinator, and a senior administrative assistant (HR). The residential program is currently staffed by seven youth care specialists and a registered nurse. In addition to the clinical director, the residential clinical component includes three counselor positions and one case manager. The community counseling program is serviced by four community counselors. The program is also supported by an intake referral specialist and a data entry clerk.

The overall findings for the program QI Review are summarized as follows:

Standard 1: There are seven indicators for Standard 1. Indicator 1.01 Background Screening of Employees/Volunteers, Indicator 1.02 Provision of an Abuse Free Environment, 1.03 Incident Reporting, and Indicator 1.04 Training Requirements were rated **Satisfactory with Exceptions.** Indicator 1.05 Analyzing and Reporting Information, Indicator 1.06 Client Transportation, and Indicator 1.07 Outreach Services were rated **Satisfactory.**

Standard 2: There are nine indicators for Standard 2. Indicator 2.01 Screening and Intake, Indicator 2.02 Needs Assessment, Indicator 2.04 Case Management and Service Delivery, Indicator 2.05 Counseling Services, Indicator 2.06 Adjudication/Petition Process, Indicator 2.07 Youth Records, and Indicator 2.08 Specialized Additional Program Services were rated **Satisfactory.** Indicator 2.03 Case/Service Plan was rated **Satisfactory with Exception.** Indicator 2.09 Stop Now and Plan (SNAP) is **Not Applicable**.

Standard 3: There are seven indicators for Standard 3. Indicator 3.02 Program Orientation, Indicator 3.03 Youth Room Assignment, Indicator 3.04 Log Books, and Indicator 3.05 Behavior Management Strategies were rated **Satisfactory.** Indicator 3.01 Shelter Environment and Indicator 3.07 Video Surveillance System were rated **Satisfactory with Exception.** Indicator 3.06 Staffing and Youth Supervision was rated **Limited.**

Standard 4: There are five indicators for Standard 4. Indicator 4.01 Healthcare Admission Screening, Indicator 4.03 Medications, Indicator 4.04 Medical/Mental Health Alert Process, and Indicator 4.05 Episodic/Emergency Care were rated **Satisfactory**. Indicator 4.02 was rated **Limited.**

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

Standard 3:
Indicator 3.06 - Limited
The staff schedule for 9/2/2023 did not show at least two staff on duty during the 2:30-11pm shift. One of the originally scheduled staff's name was crossed out and a replacement was not added.

On 11/6/2023, from 4am-6am, it was difficult to determine whether the staff physically did 15-minute bed checks between 4am-6am for the girl's dorm. Staff was observed on camera sitting in the same position and not moving; however, bed checks were documented during that period in the logbook. The program was advised to contact the CCC to make a report and later reported the report was not accepted by CCC.

Standard 4:
Indicator 4.02 - Limited
The ASR was not completed within 24 hours from the suicide risk screening for two youth. For one youth it was initiated on 8/11/23 and completed 8/18/23. The ASR was initiated for the second youth on 6/15/23 and completed 6/20/23.

The program did not use the appropriate precautionary observation (PO) log to document supervision for five suicide risk residential youth. Instead, staff documented the supervision in the program logbook but the entries did not include all the required PO information. Two of the five youth were not monitored according to policy and PO logs were missing. For one youth PO ended but there were no notes of when youth was approved to be removed from PO. The PO logs were missing for three days in another youth's record (5/19-5/20/23, and 5/23/23).

Staff documents precautionary observations logs is the program logbook; however, these entries do not include all the required PO information, including behavioral observations, any warning signs observed, and supervisory reviews of the PO log in four of the five records reviewed. The fifth youth PO logs were missing from the youth record.

None of the PO logs noted in the program logbook included supervisory reviews.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.	**Summary/Narrative Findings:** The narrative write-up is a thorough summary of each assigned QI indicator worksheet, explain how you came to your finding(s).	**Deficiencies/Exceptions:** Please add additional detailed explanations for any items that have any deficiencies or exceptions.

Standard One – Management Accountability

1.01: Background Screening of Employees, Contractors and Volunteers		**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	**NO**	
	If NO, explain here: Background Screening policy is missing additional steps required by the indicator, effective 7/1/2023, regarding timeframes for re-taking the pre-employment suitability assessment, for applicants who do not pass the initial assessment.	
	The provider has a policy and procedure titled 1.01 Recruitment and Background Screening of Employees, Volunteers, and Interns that was approved 5/1/2023 by the Program Director.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*

Total number of New Hire Employee/Intern/Volunteer Files: eight new hire files
Total number of 5 Year Re-screen Employee Files: one five-year rescreened staff file
Staff Position(s) Interviewed *(No Staff Names)*: **Senior Administrative Assistant**
Type of Documentation(s) Reviewed: Staff roster, Department of Juvenile Justice Background Screening results, Predictive Index (PI) Pre-employment Assessment, E-Verify, Annual Affidavit of Compliance with Level 2 Screening Standards

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Exception**	In response to a corrective action plan resulting from the QI Review of the Homestead program in May 2023, the program implemented the use of the Predictive Index (PI) pre-employment assessment in September 2023. A total of eight staff were hired since the last QI review for LSF Miami Bridge Central. Two are non-direct care staff and are not required to complete the pre-employment assessment. Five of six applicable new direct care staff were hired prior to the program's use of the PI and did not complete the pre-employment assessment. The sixth new hire completed the PI assessment prior to employment and received a passing score.	Five new direct staff were hired without completing a pre-employment assessment because the program was not using a screening tool at the time of their hire. The program's response to a prior corrective plan resulted in the implementation and use of the Predictive Index tool in September 2023, which was administered to one applicable staff hired in October 2023.
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	**No eligible items for review**	One applicable staff who completed the suitability assessment received a passing score.	

Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	**No eligible items for review**	None of the new hires were prior employees.	
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	**Compliance**	Background screenings for eight new hires were initiated prior to hire/start dates with eligibility documented on the DJJ background screening results. There were no exemptions required. There were no new interns/volunteers utilized during the review period.	
Five-year re-screening is completed every 5 years from initial date of hire or prior to retained fingerprints expiration date.	**Compliance**	The program had one eligible 5-year re-screen staff during the review period. A re-screening was completed timely and reflected an active retained print date with the clearinghouse.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Exception**	The program emailed its Annual Affidavit of Compliance with Level 2 Screening Standards to the Background Screening Unit May 31, 2023 after the January 31st deadline.	The program was previously cited for this exception during the QI review of its Homestead program in May 2023.
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Proof of employment authorization from the Department of Homeland Security was obtained through E-verify and maintained on file for the eight new hires.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory with Exception**
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 policy and procedure 1.02, titled Provision of an Abuse Free Environment, that was approved on May 1, 2023 by the Program Director.		
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Shelter Manager **Type of Documentation(s) Reviewed: personnel policy and procedures manual, client handbook, client grievance file** **Describe any Observations: abuse hotline postings, grievance box, grievance forms**			
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	LSF Miami Bridge's Employee Handbook includes information about the required code of conduct in two sections: 1) Code of Business Conduct, and 2) Anti-Harassment. The code of conduct clearly communicates the agency's behavioral expectations of staff that prohibits the use of any kind of abuse (verbal, sexual, or physical), harassment, threats, intimidation, and use of profanity. The handbook includes an acknowledgement of receipt for the employee to sign and the signed copy goes in the employee's personnel file.	

The agency has a process in place for reporting and documenting child abuse hotline calls.	**Exception**	Abuse calls are documented on an Abuse Registry form and maintained in a binder. A total of 10 calls were made to the hotline for residential youth. None of the calls were institutional. The calls were completely documented on the abuse reporting form for eight of the ten calls. Four of the ten hotline calls were recorded in the program logbook and six calls were noted in the youth's records.	Two of the 10 abuse reporting forms completed were missing the hotline reporter information and status of the report, to be completed by staff. Six of the 10 calls were not documented in the program logbook. Case notes were missing in the youth record for four of the 10 calls.
Youth were informed of the Abuse and Contact Number	**Compliance**	Postings of the Abuse Hotline Number was observed on a board in each dormitory, in the intake office, and counselor's office. The hotline number is included in the client handbook and reviewed with youth during orientation. One youth surveyed indicated knowledge of the hotline number and location(s) in the facility.	
Grievance			
Grievances are maintained on file at minimum for 1 year.	**Compliance**	The shelter manager maintains a file of grievances for more than year.	
There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Compliance**	The program has a formal grievance procedure in place that is reviewed with youth during intake. The shelter manager and shift lead have the keys to the grievance box. The grievance box was observed to be mounted on a wall at the entry to the girl's dormitory and forms are accessible at the same location.	
There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook.	**Exception**	Grievance checks were reviewed for randomly selected two-week periods during each of the past six months as follows: June 4-17; July 9-22; August 13-26; September 3-16; October 15--28; and November 5-18. Grievance box checks were missed for 18 of the 60 days reviewed. The QI Manager identified the issue that grievance box checks were not consistently being conducted and documented daily in the logbook. An internal corrective action plan was implemented in September 2023 with documentation to support frequent monitoring of the activities, resulting in a reduction in missed checks.	Grievance box checks were missed for 18 of the 60 days reviewed as follows: eight of 10 days in June, four times in July, two times in August, once in September, once in October, and twice in November.
All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly.	**Compliance**	A total of 17 grievances were reviewed for the QI review period; all were resolved within 72 hours.	

1.03: Incident Reporting			Satisfactory with Exception
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 titled 1.03 Incident Reporting (Risk Management), that was approved on May 1, 2023 by the Program Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Quality Management Specialist, Shelter Manager **Type of Documentation(s) Reviewed: DJJ CCC Incidents Detail Report, Program log books, and program internal incident reports reviewed over the most recent six months.**			
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	**Exception**	A total of nine CCC incidents were reported during the review period. One of the incidents is a PREA incident, based on youth on youth sexual activity, and information is blocked by CCC due to the nature of the incident. Seven of the eight incidents reported to CCC were reported within 2 hours.	One incident regarding 14 cameras not working was reported late; the shelter manager became aware of the non-operational cameras at 8pm and the call was made to CCC at 10:49pm.
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	All eight CCC reports demonstrated follow-up communication tasks/ special instructions were completed by the program.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	Incident reports are documented electronically in the agency's Converge Point System. Converge Point is an incident management and incident tracking software that simplifies incident reporting, investigations, and corrective action within a single, secure SharePoint platform. All nine incidents were recorded in the Converge Point system.	
Incidents are documented in the program logs and on incident reporting forms	**Exception**	Two of the eight incidents were documented and reported as called in to CCC in the program logbook.	Six of the eight incidents were not noted as reported to CCC in the program logbook
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	All nine incident reports recorded in the Converge Point report system showed electronic records of supervisor's signatures and follow-up.	
1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Satisfactory with Exception**
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 titled 1.04 Training Requirements, that was approved on 5/1/2023 by the Program Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Total number of New Hire Staff Files: 4
Total number of Annual In-Service Staff Files: 4
Total number of Non-Licensed Mental Health Clinical Shelter Staff Files: 0
Annual Training Plan Timeframe (*Program timeframe for annual trainings*)**: Employee's hire date anniversary.**
Staff Position(s) Interviewed *(No Staff Names)* **: Quality Assurance Manager**
Type of Documentation(s) Reviewed: Training logs, training certificates, training transcripts from Bridge and DJJ SkillPro.

First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	All four new hire pre-service training requirements were reviewed, and it was verified that all pre-service training requirements were completed.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	Four pre-service training records were reviewed and completed the required Civil Rights training within the 30 day timeframe.	
All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Compliance**	All four new staff training records were reviewed and verified each staff completed a minimum of 80 hours or more of training.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Compliance**	Four new hire training files were reviewed. Three out of the four new hires completed all mandatory training within 90 days of employment; however, one out of the four new hires did not complete Understanding Youth Development training in the 90 days. This exception was previously identified during a prior QI review and the training was completed 5/30/2023.	
Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**Compliance**	One of the four new staff is a case manager who is responsible for entering NIRVANA. The staff completed all of the required trainings.	
Staff Participating in Case Staffing & CINS Petitions (within first year of employment)			
Documentation of instructor led FL Statute 984 CINS Petition Training by a local DJJ Attorney. *Effective for staff hired after 7/1/23*	**No eligible items for review**	One applicable staff hired August 2023 is within the first year of employment and has time to complete the training.	

Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
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).	**No eligible items for review**	One applicable staff hired August 2023 is within the first year of employment and has time to complete the training.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Exception**	A review of four in-service training records found that all four staff members had completed all of the required Florida Network, SkillPro, and job-related training hours. One of the four completed all the mandatory training topics within the required annual timeframe; however, the remaining three in-service staff completed all the training but not within the required timeframe.	Three out of four in-service did not complete the required training in the annual timeframe. One of the in-service staff was hired on 7/2/2022 and did not complete the Child Abuse Reporting within the required timeframe. A second in-service staff was hired on 7/2/2022 and did not complete the Human Trafficking within the required timeframe. The third in-service staff was hired on 7/2/2022 and did not complete the Florida Network Youth Suicide Prevention and Information Security Awareness in the required annual timeframe.
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The agency's training plan, which includes all required pre-service and in-service topics, was reviewed and verified to include all required training topics for pre-and in-service staff.	
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Compliance**	The agency has designated the Quality Management Specialist (QMS) as responsible for managing all employees' individual training files and completing routine tracking and reviews of staff files to ensure compliance was reviewed and verified. The QMS is also responsible for organizing and scheduling onboarding training prior to staff working directly with youth.	
The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	The program maintains individual training files and a Florida Network Training Log for each employee, which includes an annual employee training hours tracking forms and related documentation, such as transcripts, certificates, sign-in sheets, and agendas for trainings completed**.**	
Additional Comments: **There are no additional comments for this indicator.**			

1.05 - Analyzing and Reporting Information			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**YES** If NO, explain here: The agency has the required policy and procedure titled 1.05 Analyzing and Reporting Information, that was approved on 5/1/2023 by the Program Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Quality Management Specialist, Clinical Director, Intake Coordinator** **Type of Documentation(s) Reviewed: PQI Plan, peer record reviews, FY 2023 Performance Dashboard, CQI monthly spreadsheet companion report, staff meeting agendas/minutes, monthly CQI program metrics; and monthly client satisfactions reports.**			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	Case record reviews are conducted by the clinical staff and each record review is documented on the File Review Tool that is comprised of 67 questions. The last two case record reviews were conducted in May 2023 - the last quarter of FY22-23 and September 2023- first quarter FY23-24. Upcoming changes to the tool were noted in September to include questions regarding NIRVANA. Overall findings of case reviews are reported on the CQI Monthly Spreadsheet Companion Report that is reviewed at the monthly CQI meetings.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	Incidents and accidents are entered in real time into the agency's Converge Point electronic platform. All staff has access to enter incidents in lieu of using a report form. The system tracks the types of incidents, status of reviews, and generates reports. A total of 70 incidents/accidents were reported for the period June-November 2023. Grievances are maintained in a binder and the number occurring each month is reported on the CQI Monthly Spreadsheet Companion Report and reviewed at the monthly CQI meetings. This information is also submitted to the agency's Associate Vice President of Quality Assurance.	
The program conducts an annual review of customer satisfaction data	**Compliance**	Client satisfaction data is collected and reported monthly on a Client Satisfaction Report for each program showing the number completed and overall response to nine questions as well as the percent change in response from the preceding month. The overall satisfaction rate is also reported on the CQI Monthly Spreadsheet Companion Report and reviewed at the monthly CQI meetings.	

The program conducts an annual review of outcome data and (if applicable) there is evidence of annual reconciliation that occurs through communication from the Florida Network via email or phone call when corrections are needed and the information is corrected and submitted within the requested timeframes.	**Compliance**	Performance measures are evaluated on a monthly basis by the QMS and management team. Performance indicators include a variety of areas such as staff recruitment, training and development, outreach, client satisfaction, and client functioning. These measures are reported monthly on the CQI Monthly Spreadsheet Companion Report and reviewed at the monthly CQI meetings. Additionally, the QMS conducts monthly reviews of critical program elements such as bed checks, transportation, grievances, and camera reviews to proactively monitor and respond to potential issues.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The agency also has a data entry team that communicates with program managers to reconcile corrections needed through communications from the Florida Network.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	All data collected is reviewed monthly and communicated to the local management team at the monthly CQI meetings. The agency has a robust online system for collecting and analyzing data that is displayed on the agency's CQI Analytics and Dashboard. The dashboard is accessible to the QM team and findings are regularly reviewed with staff and stakeholders.	
There is evidence the program demonstrates that critical performance data reports are shared with the Board of Directors frequently. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	LSF's Quality Assurance Department is responsible for data collection, data processing, analysis, and reporting of performance quality and improvement to the Executive Leadership Team and the Miami Bridge Board of Directors. Metrics that impact the agency are reviewed via LSF's cross-functional continuous quality improvement workgroups, committees, and departmental meetings. Per the agency's PQI, the Board of Directors/Executive Leadership reviews performance targets, including QI performance, on a quarterly basis.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	The agency has an Associate Vice President Quality Assurance and Compliance who leads the development, implementation, documentation, evaluation, and promotion of continuous improvement practices and systems. LSF Miami Bridge also has a QMS who is responsible for oversight at the local level. Processes are in place and established in the PQI plan to collect data and identify areas needing improvement. Should negative trends be observed, a corrective action will be implemented as a priority issue to be addressed and is monitored by the compliance staff as well as the program management team.	
Additional Comments: **There are no additional comments for this indicator.**			

1.06: Client Transportation		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.06	**NO** If NO, explain here: The transportation policy was not updated after May 2023 to include the changes to the indicator requiring transporting employee (during single youth transport) to check-in by phone at agreed upon intervals with the senior program leader, or designee upon arrival and departure. Employee check-ins must be documented by manager or designee receiving the call. The agency has the a policy and procedure titled 1.06 Transportation and Vehicle Management, that was approved on 5/1/2023 by the Program Director.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*

Dates or Timeframe Reviewed: E-logbook transportation logs were reviewed from June 1 to November 30, 2023.
Staff Position(s) Interviewed *(No Staff Names)* **: Program Director, Quality Management Specialist, Shelter Manager**
Type of Documentation(s) Reviewed: List of Approved Drivers, Florida Department of Highway Safety and Motor Vehicles driver's license check for authorized personnel

Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The agency maintains a list of 30 authorized drivers and per the program director, all staff 30 are approved by administration. The reviewer viewed supporting documents showing the number of employees and approved drivers licenses	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	Florida Department of Highway Safety and Motor Vehicles driver's license checks were provided for all 30 approved drivers who are covered under the agency's company 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	**Compliance**	Per the program's transportation policy, the best practice to prevent situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth is to have a 3rd party present in the vehicle while transporting a client. However, in the event a 3rd party cannot be present, the policy includes exceptions and guidelines for staff to follow.	
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	**Compliance**	The agency's policy provides provision in the event a 3rd party cannot be obtained for the transport for the consideration of the client's history, evaluation and recent behavior.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency's policy does require the 3rd party to be an approved volunteer, intern, agency staff or other youth.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Compliance**	The program conducted 54 single transport during the review period. Evidence of supervisor's approval was documented in the program logbook for all 54 transportation events.	

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.	**Compliance**	The program maintains vehicle transportation logs each time the program vehicle is used for transporting youth. The logs are documented in the program electronic logbook that includes a specific icon for transportation events and entry fields to include name of driver, date and time, mileage and number of passengers, purpose of travel and location.	
Additional Comments: **There are no additional comments for this indicator.**			
1.07 - Outreach Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: The agency has the required policy and procedure titled 1.07 Outreach Services and Interagency Agreements, that was approved on 5/1/2023 by the Program Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Program Director, Community Counseling Counselor** **Type of Documentation(s) Reviewed: DJJ Circuit Board meeting agenda and minutes, email communication with DJJ Board members, Meeting announcement flyer, printout of Netmis Outreach Activities, interagency agreements/MOUs**			
The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	**Compliance**	The community counseling counselor is the designated lead staff to attend the local DJJ council advisory board (CAB)meetings held via ZOOM. A total of three CAB meetings were scheduled during the review period in July, September, and November. Staff provided email/registration documentation to support attendance to two of the three meetings and email showing the third meeting in November was rescheduled.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The program provided a list of 45 entities with whom it has previously established an interagency agreement. The list includes providers for educational, legal, homeless, recreational, medical, mental health, LGBTQ, employment, behavioral health, and religious services. Nineteen of the 45 agreements have expired and an additional 14 do not indicate a term. The agency's new program director has already initiated requests to renew/update 22 of the 33 inactive MOUs and is currently working on establishing terms for other interested parties.	
The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	**Compliance**	The program provided the NETMIS Outreach log for July 1-December 5th, which documented 40 outreach activities/events including multiple staff members conducting the outreach activities. The NetMIS outreach log includes all required information.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	Staff required to conduct outreach who are listed on the outreach log includes program manager, counselors, intake coordinator, and youth care staff.	

Additional Comments: **There are no additional comments for this indicator.**			
2.01 - Screening and Intake			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The agency has the required policy and procedure titled 2.01 Screening and Intake Assessment, that was approved on 5/1/2023 by the Program Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 3 open community counseling youth records **Total number of Closed (Residential & Community) Files: 5 closed Residential youth records and 1 closed community counseling record** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director, intake coordinator** **Type of Documentation(s) Reviewed: Youth records**			
Shelter youth: Eligibility screening is completed immediately for all shelter placement inquiries.	**Compliance**	All five residential files reviewed demonstrated eligibility screening is completed immediately for all shelter placement inquiries.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	All four community counseling files reviewed demonstrated eligibility screening is completed within three business days of referral by a trained staff using the Florida Network screening form	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	All five residential and four community counseling files reviewed demonstrated evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	All nine files reviewed demonstrated youth and parents/guardians receive the available service options and rights and responsibilities of youth and parents/guardians in writing during intake.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**Compliance**	All nine files demonstrated the program provided the CINS/FINS parent brochure and grievance procedures during intake. An acknowledgement of review of this information is included in each youth record.	
During intake, all youth were screened for suicidality and assessed as required if needed.	**Compliance**	All nine youth files reviewed demonstrated during intake, all youth were screened for suicidality and four applicable youth were assessed further due to having a hit on the suicide screening.	
Additional Comments: **There are no additional comments for this indicator.**			

2.02 - Needs Assessment			Satisfactory
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 titled 2.02 Needs Assessment, that was approved on 5/1/2023 by the Program Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 3 open community counseling youth records **Total number of Closed (Residential & Community) Files: 5 closed Residential youth records and 1 closed community counseling record** **Staff Position(s) Interviewed (No Staff Names): Clinical Director, intake coordinator** **Type of Documentation(s) Reviewed: Youth records**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	All five residential records reviewed demonstrated NIRVANA was initiated within 72 hours of admission.	
Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**Compliance**	Three of the four community counseling files reviewed demonstrated NIRVANA was initiated at intake and completed within two to three face-to-face contacts after the initial intake. The NIRVANA was not completed in one of the files because the staff was not able to meet with the youth/family and noted failed attempts prior to the family terminating services.	
Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	**Compliance**	All nine youth files reviewed included a supervisor's signature on the completed NIRVANA assessments.	
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	**Compliance**	All five residential files reviewed demonstrated NIRVANA Self-Assessment was completed within 24 hours of youth being admitted into shelter.	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Compliance**	Five closed residential and one closed community counseling file reviewed demonstrated a NIRVANA Post-Assessment was completed at discharge.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**No eligible items for review**	None of the files reviewed were eligible for a NIRVANA re-assessment because the length of stay did not meet the 90 day requirement.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All eight applicable files reviewed included the NIRVANA interview guide and/or a printed NIRVANA. The NIRVANA was not completed in one of the files because the staff was not able to meet with the youth/family.	
Additional Comments: **There are no additional comments for this indicator.**			

2.03 - Case/Service Plan			Satisfactory with Exception
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 titled 2.03 Case Service Plan Development, that was approved on 5/1/2023 by the Program Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 3 open community counseling youth records **Total number of Closed (Residential & Community) Files: 5 closed Residential youth records and 1 closed community counseling record** **Staff Position(s) Interviewed (No Staff Names): Clinical Director, intake coordinator** **Type of Documentation(s) Reviewed: Youth records**			
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	**Compliance**	Eight applicable files reviewed demonstrated the case/service plan is developed on a local provider-approved form and is based on information gathered during the initial screening, intake, and NIRVANA. One community counseling file did not have a case plan because the family terminated services.	
Case/Service plan is developed within 7 working days of NIRVANA	**Exception**	Six of the eight files demonstrated case/Service plan is developed within seven working days of NIRVANA. Two of the community counseling files did not properly develop the case plan within seven working days of Nirvana because youth would continuously run away and due to child and guardian not being compliant.	The case plan was not developed within seven working days in one of the residential records reviewed. The NIRVANA was completed on 5/20/23 and the case plan was not developed until 11 days later on 5/31/23.
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	**Exception**	All eight case plans reviewed demonstrated individualized and prioritized need(s) and goal(s) identified by the NIRVANA, service type, frequency, location, person(s) responsible, signature of counselor and supervisor, target date(s) for completion, and date the plan was initiated. Six of the files reviewed included youth and parent signature.	Two closed residential files reviewed did not include the signature of the youth and parent/guardian on the case 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	**Compliance**	Three applicable Case/ Service plans were reviewed for progress and revised by counselor and parent every 30 days for the first three months.	
Additional Comments: **There are no additional comments for this indicator.**			

2.04 - Case Management and Service Delivery			Satisfactory
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 policy and procedure titled 2.04.01 Service Follow-up and Aftercare, that was approved on 5/1/2023 by the Program Director.		
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 3 open community counseling youth records **Total number of Closed (Residential & Community) Files: 5 closed Residential youth records and 1 closed community counseling record** **Staff Position(s) Interviewed (No Staff Names): Clinical Director, intake coordinator** **Type of Documentation(s) Reviewed: Youth records**			
Counselor/Case Manager is assigned	**Compliance**	Each of the nine files demonstrated a counselor/case manager was assigned to work with the youth/family from case assignment to termination.	
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. Monitoring of progress for court ordered youth in shelter 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	**Compliance**	All nine applicable records reviewed demonstrated referral needs were identified and coordination of referrals to services based upon the on-going assessment of the youth's/family's problems and needs. It was also evident the case worker coordinated service plan implementation, monitored youth's/family's progress in services, provided support for families, referred the youth/family for additional services when appropriate, and provided case monitoring in all ten records. None of the eight records reviewed were applicable for monitoring of progress for court ordered youth in shelter as none were reported to be court ordered during the review period. All files both residential and community counseling reviewed were not applicable to making referrals to the case staffing to address problems and needs of the youth/family, and accompany youth and parent/guardian to court hearings and related appointments as none were reported during the review period. All six closed records included termination notes. Thirty and 60 day follow ups were completed timely in six applicable files.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The program maintains written agreements with diverse community partners that include services provided and a comprehensive referral process.	
Additional Comments: **There are no additional comments for this indicator.**			

2.05 - Counseling Services			Satisfactory
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 titled 2.05 Counseling Services and Family Involvement, that was approved on 5/1/2023 by the Program Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 3 open community counseling youth records **Total number of Closed (Residential & Community) Files: 5 closed Residential youth records and 1 closed community counseling record** **Staff Position(s) Interviewed (No Staff Names): Clinical Director, intake coordinator** **Type of Documentation(s) Reviewed: Youth records**			
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	LSF Miami Bridge provides individual and family counseling. Residential youth received individual and family counseling as evident by the counseling notes in the five residential youth records.	
Group counseling sessions held a minimum of five days per week	**Compliance**	All youth participated in group sessions once a week and the program offers group sessions according to log books and schedules five days a week.	
Groups are conducted by staff, youth, or guests and group counseling sessions consist of : 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer	**Compliance**	All groups were very clearly documented in the group log book and included a leader and the topic discussed. An attendance was taken during class to show participants present and duration of class was also shown on the group log.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	Case manager provided documentation of groups. Group sessions consisted of a clear leader or facilitator, relevant topic, date and time of group, list of participants, an opportunity for youth to participate, and the length of groups was at minimum thirty minutes.	
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.	**Compliance**	All three youth who participated in the community counseling program were provided therapeutic community-based services directly or through referrals. The goal of the services are to provide the intervention necessary to stabilize the family. Services were provided in an approved location.	
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	**Compliance**	All of the files reviewed reflected coordination between presenting problem(s), psychosocial assessment, case/service plans, case/service plan reviews, case management, and follow-up when applicable.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	**Compliance**	All of the youth records were maintained in individual case files with adherence to all laws regarding confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress	**Compliance**	Case notes were maintained in all of the files indicating the youth's progress as well as case notes for all services provided.	
On-going internal process that ensures clinical reviews of case records and staff performance	**Compliance**	All cases reviewed undergo a process that ensures clinical reviews of case records and staff performance. In addition peer record reviews are conducted monthly for a sample of case records and deficiencies are identified and addressed by management.	
Additional Comments: **There are no additional comments for this indicator.**			
2.06 - Adjudication/Petition Process			**Satisfactory**
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 titled 2.06 CINS Adjudication and Petition Process, that was approved on 5/1/2023 by the Program Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Clinical Director **Type of Documentation(s) Reviewed: Policy & Procedures**			
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	Per interview with the Clinical Director, there were no adjudication/petitions filed or case staffing held during the review period. The agency's policy and procedure was reviewed to determine compliance. If requested, at a minimum, the program's case staffing committee is comprised of a DJJ representative or CINS/FINS provider and a local school district representative. All required representatives are invited and each documentation for case staffing kept in case staffing log book with signatures.	
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	**Compliance**	Per the program's policy and procedure, other members of the committee may include: State Attorney's Office; others requested by youth/ family; substance abuse representative; law enforcement representative; DCF representative; and mental health representative.	

The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The agency has established a case staffing committee in the event the youth/family is not in agreement with services or treatment; the youth/family will not participate in the services selected; or the program receives a written request from a parent/guardian or any other member of the committee.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	The case staffing meetings will be held if requested, including emergency case staffing. Members of the committee are notified via email when a case staffing is scheduled to be convened.	
The youth and family are provided a new or revised plan for services	**No eligible items for review**	No case staffings were held 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	**No eligible items for review**	No case staffings were held since the last QI review.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	No case staffings were held since the last QI review.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	No case staffings were held since the last QI review.	
Additional Comments: **There are no additional comments for this indicator.**			
2.07 - Youth Records			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The agency has the required policy and procedure titled 2.07 Youth Manual and Electronic Medical Records, that was approved on 5/1/2023 by the Program Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Clinical Director **Type of Documentation(s) Reviewed: Policy and Procedure, Client Case Files** **Describe any Observations: File cabinet, record storage/transport container, and file room**			
All records are marked “confidential”	**Compliance**	The program uses Lauris online electronic file system instead of manual files. All additional youth record documentation provided during the review were clearly marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked “confidential”	**Compliance**	All youth related records were observed to be kept in a secure room or locked in a file cabinet that is marked “confidential”	

When in transport, all records are locked in an opaque container marked “confidential”	**Compliance**	The program has a container that is used to transport records off site. The storage container is marked confidentiality and equipped with a lock. Program laptops are encrypted and password protected for confidentiality and safety.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	The records are electronic and are password protected and encrypted for confidentiality. Lauris prompts the staff to change password frequently in order to access and use the system.	
Additional Comments: **There are no additional comments for this indicator.**			

2.08 - Specialized Additional Program Services			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.08	**YES**		
	If NO, explain here:		
	The agency has the required policy and procedure titled 3.07 Special Populations, that was approved on 5/1/2023 by the Program Director.		
Staff Secure			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Clinical Director**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**No eligible items for review**	LSF Miami Bridge has not served any youth who meet the criteria for Staff Secure services since the last QI review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**No eligible items for review**		
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	**No eligible items for review**		
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	**No eligible items for review**		
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**		
Domestic Minor Sex Trafficking (DMST)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Clinical Director			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	LSF Miami Bridge has not served any youth who meet the criteria for Domestic Minor Sex Trafficking (DMST) services since the last QI review.	

Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	**No eligible items for review**		
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.	**No eligible items for review**		
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**		
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	**No eligible items for review**		
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	**No eligible items for review**		
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	**No eligible items for review**		
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**		
Domestic Violence			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Closed Files: 3 closed DV Respite youth records **Staff Position(s) Interviewed** *(No Staff Names)* **: Intake Coordinator** **Type of Documentation(s) Reviewed: Youth records**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	A total of three closed residential DV youth records were reviewed.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	All three records reviewed have face sheets in their files with documentation to show the three youth have pending DV charge and were referred to the shelter for DV respite.	

Data entry into NetMIS within (3) business days of intake and discharge	**Compliance**	The three youth records were reviewed in NetMIS and data entry was verified to be completed within three business days of intake and discharge.	
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**Compliance**	One of the three youth had a placement in DV Respite for 21 days. exceeded 21 days. Documentation in the youth's file show the recorded was terminated from DV and transitioned to CINS/FINS.	
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**Compliance**	The case plan for one youth reflected goals for anger management and family coping skills. The other two youth records show that they initiated the program but went on runaway and did not returned to continue services and initiate a case plan.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	All three files reviewed demonstrated youth participated in services consistent with other general CINS/FINS population while in care.	
Probation Respite			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Clinical Director			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The program has not served any youth who met the criteria for Probation Respite in the last 6 months or since the last onsite QI review.	
All probation respite referrals are submitted to the Florida Network.	**No eligible items for review**		
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**No eligible items for review**		
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**No eligible items for review**		
Length of stay is no more than fourteen (14) to thirty (30) days. Any placement beyond thirty (30) days contains evidence in the file that the JPO was contacted in writing to request the need of an extension no later than the 25th day the youth was admitted into the program.	**No eligible items for review**		
All case management and counseling needs have been considered and addressed	**No eligible items for review**		

All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**		
Intensive Case Management (ICM)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Clinical Director			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Not Applicable**	LSF Miami Bridge does not have a contract to provide ICM services.	
Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	**Not Applicable**		
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	**Not Applicable**		
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**Not Applicable**		
Service/case plan demonstrates a strength-based, trauma-informed focus	**Not Applicable**		
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	**Not Applicable**		
Family and Youth Respite Aftercare Services (FYRAC)			

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Clinical Director			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The program has not served any youth who met the criteria for FYRAC in the last 6 months or since the last onsite QI review.	
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	**No eligible items for review**		
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**No eligible items for review**		
Intake and initial assessment sessions meets the following criteria: a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file. b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan. c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan.	**No eligible items for review**		
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Services are highly supportive, individualized, and flexible and require a "whole family" approach to dealing with the problems affecting the youth and family.	**No eligible items for review**		

Individual Sessions: a.The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning. b. Issues to be covered through each session include but are not limited to: Identifying emotional triggers; body cues; healthy coping strategies through individual, group and family counseling; understanding the cycle of violence and the physical and emotional symptoms of anger; developing safety plans; and educating families on the legal process and rights.	**No eligible items for review**		
Group Sessions: a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence. b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session	**No eligible items for review**		
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**No eligible items for review**		
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	**No eligible items for review**		
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**No eligible items for review**		
All data entry in NetMIS is completed within 3 business days as required.	**No eligible items for review**		
Additional Comments: **There are no additional comments for this indicator.**			

2.09- Stop Now and Plan (SNAP)			Not Applicable
Provider has a written policy and procedure that meets the requirement for Indicator 2.09	**N/A**		
	If NO, explain here:		
	LSF Miami Bridge is not a SNAP provider.		
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Program Director			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Not Applicable**	LSF Miami Bridge is not contracted to provide SNAP services.	
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**		
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Not Applicable**		
There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file.	**Not Applicable**		
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Not Applicable**		
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Not Applicable**		
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Not Applicable**		
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Not Applicable**		
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	**Not Applicable**		
The Consent to Treatment and Participation in Research Form is completed and located within the file.	**Not Applicable**		
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**		
There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		
There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		

There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		
SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. (*This must include a total of 13 attendance sheets for a full cycle*)	**Not Applicable**		
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	**Not Applicable**		
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Not Applicable**		
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Not Applicable**		
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**Not Applicable**		
Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			**Satisfactory with Exception**
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 titled 3.01 Shelter Environment, that was approved on 5/1/2023 by the Program Director.		

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*

Staff Position(s) Interviewed: Shelter Manager
Type of Documentation(s) Reviewed: Weekly and perpetual chemical inventory, MSDS, Fire Drills, Emergency Drills, Miami Dade County Fire Inspection, Fire equipment inspection, Department of Health Inspections, activity and program schedule.
Describe any Observations: Tour of facility, postings, inspection of agency vehicle, chemical storage

Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	**Compliance**	A tour of the facility was conducted with the Shelter Manager. All furnishings are in fair condition and are pending replacement as the boys male and female dorm will be remodeled in the near future, per shelter manager. No evidence of infestation was observed during the tour. In the facility there is one staff bathroom, three bathroom and showers in the boy's dorm, and three showers and bathrooms in the girl's dorm. No sign of water leakage was evident and all faucets in the male, female, and staff bathroom are in good condition and have running water. A foul odor was detected in the kitchen area and the reviewer was informed animal control was contacted because it was suspected there was a decaying animal carcass in the crawl space under the building. Windows, walls, and doors are free of graffiti and appear to be in fair condition. Lighting is adequate in all areas of the facility. The exterior area was free of debris and ground was free of hazards. The dumpster was completely full so the lid was open. All doors in/out of the facility are secure with a universal code and entry is limited to staff who have a key fob. Egress maps are posted in the day room, dorms, and administrative office. A grievance box and forms are located in the day room. Abuse hotline info and DJJ incident reporting is posted in the staff office and each dorm. No contraband was observed in the facility.	
Facility Inspection: a.All agency and staff vehicles are locked. b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.	**Compliance**	Reviewer inspected one agency van, a 2015 Chevrolet, located the campus but it was out of commission it is in the process of being fixed per maintenance staff. An estimate documentation was provided. The vehicle was found with all safety equipment needed, which included first aid kit, fire extinguisher, flashlight, glass breaker and seatbelt cutter.	

Facility Inspection: All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely and Material Safety Data Sheets (MSDS) are maintained on each item (minimum 1 time per week or per agency policy). A perpetual inventory will be the primary means of maintaining a current and real-time inventory. The weekly inventory will be conducted weekly at a minimum to ensure that a perpetual inventory is being maintained consistently and accurately. If more than one location is used to store chemicals, there is an inventory wherever chemicals are stored that is current and well maintained unless previously approved by the Network.	**Exception**	The agency has a weekly inventory for all chemicals used in the facility including: Mr. Clean finished floor cleaner, Spic & Span Disinfecting All purpose and glass cleaner, Victoria Bay hand sanitizer, Easy Off, Victoria Bay Soap, and Victoria Bay Toilet bowl cleaner. A perpetual inventory is also used when the chemicals are removed for use from the storage closet. MSDS sheets were missing for some of the chemicals in use in the facility. Easy Off, Victoria Bay Soap, and Victoria Bay Toilet bowl cleaner.	MSDS sheets were missing for Easy Off, Victoria Bay Soap, and Victoria Bay Toilet bowl cleaner.
Facility Inspection: Washer/dryer are operational & general area/lint collectors are clean. Agency has a current DCF Child Care License which is displayed in the facility. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket. Youth have a safe, lockable place to keep personal belongings, if requested.	**Compliance**	All washers and dryers are functional with the exception of one dryer with a small amount of lint in the lint collector. The facility is licensed for 20 beds and the current DCF Child Care License displayed in the lobby is effective 6/1/2023. Each youth has their own individual bed with clean covered mattress, and pillow. No youth were housed in the facility during the review so the beds were only covered with mattress protectors. Youth have access to a safe for storage of valuable, personal items, which is located in the staff office and is kept locked.	
Additional Facility Inspection Narrative (if applicable)			
Fire and Safety Health Hazards: a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. b. Agency completes a minimum of 1 fire drill per month within 2 minutes or less. c. Completes 1 mock emergency drill per shift per quarter. d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).	**Exception**	Facility's annual fire inspection was conducted 5/9/2023 by Miami Dade Fire Department and was found to be compliant. The program completed fire drills monthly on each shift with evacuation time within 2 minutes or less from June - November 2023. There was a minimum of one mock emergency drill completed quarterly from June-Nov 2023 on the first and third shifts with the exception of one missed emergency drill on the second shift in July of 2023. Three fire extinguishers, two located in the day room and one in the agency van, were inspected on 12/5/2023.	The second shift missed a quarterly mock emergency drill in July 2023

Fire and Safety Health Hazards: a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health. b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually. c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored. d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.	**Exception**	This agency has satisfactory residential group care and food inspection conducted by the State of Florida Department of Health. Group care inspection was completed on 12/5/2023 and the food inspection was completed on 9/18/2023. The food menus are posted on the wall in the kitchen and were approved in 2021 by a licensed dietician. All cold food was properly stored at optimal temperatures but not all items were observed to be marked and labeled. The pantry was clean and food is properly stored above the ground. Two refrigerators were maintained between 29 and 38 degrees Fahrenheit and the freezer temperature was -2 degrees Fahrenheit.	Meat stored in the freezer was not dated. The pantry did not have dates on dry storage items, with exception of two boxes that were labeled.
Additional Fire and Safety Health Hazards Narrative (if applicable)			
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.	**Compliance**	Due to staffing shortage and ongoing construction, as of 11/17/2023, no youth were being housed in the facility but were transferred to the Homestead location. The program has an established schedule that includes different activities ranging from education to faith based, group, recreation, and social skills trainings. The schedule is visibly posted in the intake office and dorms and includes educational activities and time needed to complete educational assignments.	
Additional Comments: **There are no additional comments for this indicator.**			
3.02 - Program Orientation			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES** If NO, explain here: The agency has the required policy titled 3.02 Program Orientation that was approved May 1, 2023 by the Program Director.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Closed Files: 3 closed youth records **Type of Documentation(s) Reviewed: Client handbook**			
Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	All 3 youth files have a checklist indicating the youth received a comprehensive orientation within 24 hours.	
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility I. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**Compliance**	All files have a checklist with the staff and youth's signature indicating the youth received a comprehensive orientation explaining the disciplinary action, program rules, grievance procedure and emergency procedures, the contraband policy, suicide prevention, tour, room assignment and how to contact the abuse hotline.	
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	**Compliance**	The orientation checklist includes each component of orientation that is reviewed with the youth as well as signatures of the youth and staff involved. A copy of the orientation checklist was present in each of the three files reviewed and were signed by the youth, parent/guardian, and staff,	
Additional Comments: **There are no additional comments for this indicator.**			
3.03 - Youth Room Assignment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.03		**YES** If NO, explain here: The agency has the required policy titled 3.03, Youth Room and Bed Assignment - Youth Safety, that was approved May 1, 2023 by the Program Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Closed Files: 3 closed residential youth records **Type of Documentation(s) Reviewed: intake and admission documentation**			

A process is in place that includes an initial classification of the youths, to include:			
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk I. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation	**Compliance**	All files show documentation of staff gathering information of the youth's history and exposure to trauma, age, and gender, history of violence, disability, physical size and gang affiliation. All files show documentation of the youth's sexual behavior, sexual orientation, suicide risk and if isolation is necessary.	
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	**Compliance**	All files show documentation of noted alerts, collateral contacts and the youth's initial interactions and observations.	
Additional Comments: **There are no additional comments for this indicator.**			
3.04 - Log Books			**Satisfactory**
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 titled 3.04 Log Books (Manual and Electronic), that was approved May 1, 2023 by the Program Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: Logbook entries June 4-17th; July 9th-22nd; August 13th-26th; September 3-16th; October 15th-28th; and November 5th-18th. **Type of Documentation(s) Reviewed: E-logbook**			
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	The agency uses a highlight system for the e-logbook which is consistent and easy to follow. The highlight system helps to distinguish and track significant activity. The occurrence of fire drills, youth movement and critical incidents was highlighted as well as activities which could impact the security and safety of the youth or the program.	
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	**Compliance**	All entries are typed in the electronic logbook and are therefore legible. The entries include date and time of the incident, event or activity, names of youth and staff involved, brief statement regarding the entry, and name and signature of person making the entry.	

Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**Compliance**	The e-logbook allows for any corrections needed to be typed and include the date and initial of person making the correction.	
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	**Compliance**	It was observed during the review of the logbook that the shelter manager or designee reviewed the logbook on a regular basis, sometimes several times during the week. The supervisory entries include the dates reviewed and if any correction, recommendations and follow-up are required.	
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	**Compliance**	It was observed that staff have a sign-in/sign-out system in the logbook based on logbook entries reviewed for the random weeks between June-Nov 2023.	
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.	**Compliance**	Logbook entries reviewed demonstrate both shelter manager and counselor review the logbook at the beginning of their shifts for all shifts since their last shift worked and indicate the dates reviewed.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	Logbook entries show staff consistently documenting the movement of youth in the building and when youth were off campus for different situations.	
Additional Comments: **There are no additional comments for this indicator.**			
3.05 - Behavior Management Strategies			**Satisfactory**
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 titled 3.05 Behavior Management Strategies and Intervention, that was approved May 1, 2023 by the Program Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Shelter Manager **Type of Documentation(s) Reviewed: Policy and procedure, BMS protocol, staff training records, point charts**			
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	The agency implemented a new Behavior Management system (BMS) called Journey to Success. During intake and orientation the youth are informed of the BMS. The program rules and behavioral expectations are explained during orientation.	
Behavior Management Strategies must include:			

a.BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b.Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c.BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d.Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e.Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f.Only staff discipline youth. Group discipline is not imposed g.Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h.Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	**Compliance**	Journey to success which is a weekly point level system and rewards program that is designed to teach and encourage new behaviors. Points range from 0-630 points. The BMS captures each youth's daily behavior and their level of points for day throughout the week. Each youth's points log is provided to their counselor at the end of the week to address any behavior. A variety of positive incentives are used including exchanging points for one item from the reward closet which could be candy, snacks, personal items, or electronics. BMS protocol appears to promote safety, fairness, intent to encourage positive reinforcement and behavior modification with privileges/incentives and consequences. Disciplinary actions do not deny the youth of any of their basic rights.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	Journey to success was implemented by the program in May 2023 at which time all existing staff attended the 6 hours foundations and implementation training. New staff are trained in the BMS during onboarding.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	Feedback is provided to staff daily or during employee of the month. The shelter manager consistently commends the staff for a job well done.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	Training documentation showed all supervisory staff are trained in the BMS and to monitor the use of rewards and consequences by their staff.	
Additional Comments: **There are no additional comments for this indicator.**			

3.06 - Staffing and Youth Supervision			Limited
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 titled 3.06 Staffing and Youth and Staff Supervision, that was approved May 1, 2023 by the Program Director.		
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: June-November 2023 **Staff Position(s) Interviewed** *(No Staff Names)* **: Shelter Manager** **Type of Documentation(s) Reviewed: Staff schedules for June-November 2023, bed check dates/times as follows: November 10th, 12am-2am; November 15th, 2am-4am; November 19th, 4am-6am; November 25th 1am-3am; and December 4th 3am-5am.** **Describe any Observations: Posting of staff schedule and staff rotation roster**			
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	**Compliance**	A review of staff schedules, and logbook entries for the review period documented the required staffing ratios were met for the awake hours one staff to six youth and during sleeping hours, at least one staff to 12 youth.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Exception**	Staff schedules for June 2023 - November 17th showed at least two staff on all shifts with the exception of one staff that was missing for 2:30pm-11pm on September 2, 2023. The 2nd person scheduled for 2:30-11pm was crossed out.	The staff schedule for 9/2/2023 did not show at least two staff on duty during the 2:30-11pm shift. One of the originally scheduled staff's name was crossed out and a replacement was not added.
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	**Compliance**	All new staff hired were background screened and property trained youth care workers. A review of eligible re-screened staff indicate continued eligible screening results for the applicable staff.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The staff schedule is posted in the intake staff office. On call supervisor schedule is updated on a weekly basis but staff phone numbers are posted in the shelter manager's office and not in the staff office due to clients potentially having access to the office.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	There is a staff rotation posted in staff office. Per the shelter manager, the same 2 staff are on call for a period three months, then it changes. In the event either of the two staff is not available then the staff working during that shift are asked to remain to cover the shift.	

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	**Exception**	Bed Check Dates/Times randomly selected and reviewed are: November 10th, 12am-2am; November 15th, 2am-4am; November 19th, 4am-6am; November 25th 1am-3am; and December 4th 3am-5am. Five random shifts were reviewed and all 15 minute bed checks were completed with the exception of the checks on 11/2/2023.	On 11/6/2023 from 4am-6am, it was difficult to determine whether the staff physically did bed checks between 4am-6am for the girl's dorm. Staff was observed on camera sitting in the same position and not moving; however, bed checks were documented during that period in the logbook. The program was advised to contact the CCC to make a report; the report was not accepted by CCC.
Additional Comments: **There are no additional comments for this indicator.**			
3.07 - Video Surveillance System			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.07		**YES** If NO, explain here: The agency has the required policy and procedure titled 3.08 Video Surveillance System, that was approved May 1, 2023 by the Program Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: November 10th, 12am-2am; November 15th, 2am-4am; November 19th, 4am-6am; November 25th 1am-3am; and December 4th 3am-5am **Staff Position(s) Interviewed** *(No Staff Names)* **: Shelter Manager** **Type of Documentation(s) Reviewed: 15-minute bed check entries in the logbook, video camera review documentation** **Describe any Observations: Video surveillance system**			
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	**Compliance**	The program has cameras that are visible in the interior and exterior to cover all general locations. Cameras are placed in the day room, entrance, and down halls ways, dining area, recreation area, lobby area. A total of 32 cameras are installed in the facility. Cameras are clear with exception of one camera in the girl's dorm. When completing video surveillance there was a light covering the area where the camera is positioned that makes it difficult to see if staff completed is completing bed checks. This was brought to shelter manager and QA manager attention. A notice is posted at the front entrance that the facility is being monitored 24 hours a day. The surveillance system can store video for a minimum of 30 days, record date, time, and location; enables facial recognition; and has back-up capabilities to operate during a power outage.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	The shelter manager maintains a list of designated personnel who can access the surveillance system.	

Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	Supervisory review is conducted bi-weekly by the shelter manager and documented to assess the activities of the facility. The QMS also conducts random video reviews and include the findings in the monthly CQI meetings.	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	Supervisory and QMS reviews of the video surveillance include 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	**Compliance**	The agency has a practice in place in which video is made available within 24-72 hours for the purpose of investigating allegations of incidents and to accommodate quality improvement visits.	
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	**Exception**	The shelter manager discovered 14 cameras were not working on Thursday 7/27/23. IT was contacted and a technician was supposed to show up on Monday 7/31/23. The cameras were not fixed until another 10 days later on 8/10/23	All efforts must be made to place camera service order requests within 24 hours of discovery and to expedite repairs In order to ensure cameras are operational with the least amount of down time.
Additional Comments: **There are no additional comments for this indicator.**			
4.01 - Healthcare Admission Screening			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.01		**YES** If NO, explain here: The agency has the required policy and procedures titled 4.01 Healthcare Admission Screening (Physical Health Screening) that was approved December 7, 2023 by the Program Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Closed Files: 5 closed residential files			
Preliminary Healthcare Screening			
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	**Compliance**	A total of five residential youth closed files were reviewed. The program's healthcare screening form includes all of the conditions required. Two of the five closed files were on medication and one of the five had existing chronic conditions. Healthcare Admission Screening Forms were completed at the time of intake by direct care staff for all files reviewed and were completed in its entirety. All youth files reviewed reflected that a review of Health Care Admissions Screening/Intakes was completed by the Nurse or designated staff.	

Referral and Follow-Up			
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	**Compliance**	None of the client files reviewed needed medical follow up. However, there were three youth with chronic medical conditions and each had a referral. An interview with the program's registered nurse reported that medical follow up referrals are documented in the electronic medical record on the Medical Documentation form, staff communication binder, and client medical file which was also observed.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**Compliance**	Two of the records indicated the parent/guardian needed to be involved in healthcare services while the youth were in the program. Documentation in the electronic medical records indicated each youth parent was involved with the co-ordination of service needed.	
All medical referrals are documented on a daily log.	**Compliance**	Each youth electronic medical record indicated all healthcare referrals are documented on a daily log maintained in the youth electronic medical record.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The program's policy states they will work with the youth's parent/guardian and the provider's medical consultant, if needed, to ensure the youth receives proper medical care and follow-up.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Limited**
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 procedures titled 4.02 Suicide Prevention, that was approved May 1, 2023 by the Program Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Closed (Residential & Community) Files: 5 residential and one community counseling **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director** **Type of Documentation(s) Reviewed: Precautionary observation logs, Assessment of Suicide Risk**			
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
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.	**Compliance**	Documentation verified all six youth received a suicide risk screening during the initial intake and screening process. Each reviewed suicide screening result was reviewed and signed by a licensed supervisor and was maintained in the youth electronic record.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services.	

Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Exception**	Documentation verified an assessment of suicide risk (ASR) was completed for all five residential youth who were placed on the appropriate level supervision based on the result of the suicide risk assessment. Three of the ASR were completed within 24 hours as required.	The ASR was not completed within 24 hours from the suicide risk screening for two youth. For one youth it was initiated on 8/11/23 but was not completed until 8/18/23. The ASR was initiated for the second youth on 6/15/23 but was not completed until 6/20/23.
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	**Exception**	The staff person(s) assigned to monitor the youth must document his/her observations of the youth's behavior at 30 minute or less intervals using either an precautionary observation (PO) log or in the shelter daily log. Documentation should include time of day, behavioral observations, any warning signs observed and the observer's' initials. Documentation must be reviewed by supervisory staff each shift. If using a PO log, once it is completed, it must be placed in the youth's file. Staff documents observation is the program logbook; however these entries do not include all the required PO information, including supervisory reviews of the PO log. As a result, the required observations were not made and/or documented for any of the five residential suicide risk youth.	The program did not use the appropriate observation log to document supervision for five suicide risk residential youth. Instead, staff documented the supervision in the program logbook but the entries did not include all the required PO information. Two of the five youth were not monitored according to policy and PO logs were missing. For one youth PO ended but there were no notes of when youth was approved to be removed from PO. The PO logs were missing for three days in another youth's record (5/19-5/20/23, and 5/23/23).
Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log.	**Exception**	The program did not document all required PO information in logbook while supervising four of the five youth. No logs were observed for one of the youth.	Staff documents precautionary observations logs is the program logbook; however, these entries do not include all the required PO information, including behavioral observations, any warning signs observed, and supervisory reviews of the PO log in four of the five records reviewed. The fifth youth PO logs were missing from the youth record.
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	**Compliance**	In one applicable youth record documentation showed compliance. The youth's supervision level was not changed to standard supervision until the youth received a follow up Suicide Risk Assessment by the licensed clinician.	
There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.	**Exception**	In four of the five residential records reviewed, the program documents observation in their own program precautions observations (PO) log; however, each of the four youth PO log entries do not include all the required PO log information, including supervisory reviews of the PO log. The fifth youth observation logs were missing.	None of the PO logs noted in the program logbook included supervisory reviews.
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**Compliance**	One applicable closed community youth record documented a suicide risk assessment was immediately completed by a non-licensed professional under the direct supervision of a licensed mental health professional during intake. Documentation supported the youth parents and supervisor were notified of the youth results.	

During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**Compliance**	Documentation showed youth was referred and parent was notified. Documentation showed the youth Assessment of Suicide Risk was completed by the program licensed professional.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**Compliance**	Documentation showed for the one applicable youth information was provided to the parent/guardian. Documentation also showed Information on resources available in the community for further assessment was provided to the youth parent and was documented in the youth electronic file and signed by the youth parent.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Compliance**	The program staff was able to contact the youth parents and all contacts were documented in the youth electronic file.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Compliance**	Documentation showed the screening was completed during school hours on school property and the appropriate school authorities were notified.	
Additional Comments: **There are no additional comments for this indicator.**			
4.03 - Medications			**Satisfactory**
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 procedures titled 4.03 Medications (Storage, Access, Inventory, Administration, Documentation and Disposal), that was approved May 1, 2023 by the Program Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Closed Files: 3 **Staff Position(s) Interviewed** *(No Staff Names)* **: registered nurse** **Type of Documentation(s) Reviewed: Youth medical records, medication distribution records, Pyxis reports, medication inventory** **Describe any Observations: Observations of the Pyxis medication cart, cart contents, location of the medication cart, medication inventory**			
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	The program has one registered nurse (RN) and documentation showed the RN credentials have been verified and clear.	

Medication Storage			
a. All medications are stored in a Pyxis ES 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 Pyxis ES 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	**Compliance**	The program currently did not have youth on site; however, Pyxis machine is stored inside the medical office. There is a refrigerator with temperature for medication requiring refrigeration in the room as well. Oral medications are stored separately from injectable epi-pen and topical medications. The program does not accept any youth prescribed injectable medication except for epi-pens. Observation supported the Pyxis machine is stored in accordance with guidelines in FS 499.0121 and the program policy section in Medication Management. Also, the Pyxis keys were labeled and are accessible to only staff in the event they need to access medications if there is a Pyxis malfunction.	
Medication Distribution			
a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES 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 three methods listed in the FNYFS Policies & Procedures 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	**Compliance**	Documentation showed all the program staff are trained on medication management, and have access to secured and all medications. There are a minimum of two system managers for the Pyxis machine. Only designated staff delineated in user permissions have access to controlled substances. A medication distribution log is utilized for all medication distribution by licensed or non-licensed staff. The program verifies medications using one of the three methods listed in the FNYFS Policies and Procedures Manual. When the nursing staff are on duty, medication process are conducted by the nurse. The delivery process of medication is consistent with The Florida Network of Youth and Family Services (FNYFS) medication management and distribution policy. The nursing staff verify medication using the approved methods listed in the FNYFS Operations Manual. The program does not accept youth requiring prescribed injectable medications, except for epi-pens. All non-licensed staff have received training from the program nurses on the use of epi-pens, with refreshers completed each time a new youth is admitted to the program with one.	
The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given c. evidence of staff initials that the dosage was given	**Compliance**	A total of three applicable youth closed residential records were reviewed. Documentation on each youth medication distribution log documented the time of medication, youth initials, and staff initials who gave the dosage.	

There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Compliance**	A total of three applicable youth closed residential records were reviewed. All three applicable youth closed records indicated medications was provided within one hour of the scheduled time. There was no instance where youth was not provided medication within the required timeframe during the review period.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	A total of three applicable youth closed residential records were reviewed. There were no instances found of youth missing their medication due to failure to open the pyxis machine.	
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	**Compliance**	The program currently did not have youth on site during the annual review; therefore, closed youth files information were reviewed. The program reported there was one youth closed record applicable for controlled substances medication during the review period. Documentation indicated the youth controlled substances medication was counted from shift-to-shift by two staff, and there were staff signatures. Non-controlled and over-the-counter medications are inventoried weekly in addition to the documented perpetual count. Documentation reflects sharps and syringes are secured and counted weekly.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	Documentation supported there are monthly reviews by the program nurse of the Pyxis reports to monitor medication management practice.	
Medication discrepancies are cleared after each shift.	**Compliance**	The program currently did not have youth on site during the annual review. Documentation supported if there are medication discrepancies it was cleared during each shift.	
The agency has an internal quality assurance process to ensure appropriate medication management and distribution methods.	**Compliance**	The program has an internal quality assurance process to ensure appropriate medication management and distribution methods are follows. Medication related issues identified are monitored by the QMS and reviewed during monthly CQI meetings.	
Additional Comments: **There are no additional comments for this indicator.**			

4.04 - Medical/Mental Health Alert Process			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.04		**YES** If NO, explain here: The agency has the required policy and procedures titled 4.04 Medical and Mental Health Alert Process, that was approved May 1, 2023 by the Program Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Closed Files: 5 residential files **Staff Position(s) Interviewed** *(No Staff Names)* **: RN** **Observation: Alert board**			
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	A total of five closed residential files were reviewed. All five youth records were in compliance. Each of the youth records reviewed indicated the youth had medical, mental health condition and/or food allergies. All five youth were placed in the program's alert system which includes precautions concerning prescribed medications, mental health conditions, allergies and medication side effects.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The program's alert system includes precautions concerning the prescribed medications, medical and mental health conditions. Alerts are documented in the medical book and on each youth electronic medical record. An alert board located in the intake office also documents the youth name and alert in a confidential manner. A nutritional alert form will be in the kitchen which includes a list of youth who have an allergy or other kind of nutritional alert. All five youth closed residential records were in compliance. The program currently did not have youth on site during the annual review for observation of the process.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	An informal interview with the program's RN reported all the staff are provided sufficient training information and instructions to recognize/respond to the need for emergency medical/mental health problems which was observed in a total of eight staff training files reviewed	

A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**Compliance**	The program's alert system is in place to ensure information concerning youth medical condition and mental health treatment information is communicated to all staff. Each of the five residential youth record demonstrated alerts were documented in the files and communicated to staff.	
Additional Comments: **There are no additional comments for this indicator.**			
4.05 - Episodic/Emergency Care			**Satisfactory**
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 procedures titled 4.05 Episodic / Emergency Care, that was approved May 1, 2023 by the Program Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: RN** **Type of Documentation(s) Reviewed: episodic care log, logbooks**			
Off Site Emergency Care			
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	**No eligible items for review**	The program reported there were no episodic/emergency care for the past six months or since the program re-open on June 2023.	
All staff are trained on emergency medical procedures	**Compliance**	A total of eight staff training records were reviewed. Documentation supported all the staff received training on emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	In total, the program has 4 knife-for-life and 5 wire cutters that were in secure locations. Observation showed the knife-for-life and wire cutters are accessible to all staff. Knife-for-life are located in each building and transportation vans; wire cutters are located in the intake office, kitchen, community services building, and one on each van.	
Additional Comments: **There are no additional comments for this indicator.**			