Florida Network for Youth and Family Services
Compliance Monitoring Report for

LUTHERAN SERVICES FLORIDA – MIAMI BRIDGE (HOMESTEAD)

326 NW 3 Avenue
Homestead, Fl 33030

April 24-25, 2024

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the Lutheran Services Florida Miami Bridge Homestead (LSF Miami Bridge Homestead) for the FY 2023-2024 at its program office located at 326 NW 3 Avenue, Homestead. 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 Homestead 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 Paula Friedrich, Duane Gross, Nathaly Milla, and LaToya Robinson. Agency representatives from LSF Miami Bridge Homestead present for the entrance interview were: Jose Fontanez, Program Director; C.J. Fernandez, QA Management Specialist; Tracy Scott, Registered Nurse; and Lashonda Chavis, Intake Coordinator. The last onsite QI visit was conducted May 31- June 1, 2023.

In general, the Reviewer found that LSF Miami Bridge Homestead is in compliance with specific contract requirements. LSF Miami Bridge Homestead **received an overall compliance rating of 100% for achieving full compliance with 12 of the 12 applicable indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit; however, one (1) recommendation was made for an indicator rated as conditionally acceptable.

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

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 04-24-2023-2024

Agency Name: Lutheran Services Florida Miami Bridge (Homestead)	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office:** 326 NW 3 Avenue, Homestead, FL 33030
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 24-25, 2024**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	Documentation: Peer training list. Miami Bridge has two locations and the agency currently has three staff members certified as DJJ QI Peer reviewers: Lashonda Chavis, Citizen Fernandez, and Jose Ortega. Former peer reviewer Ashley Wooten is no longer with the agency, resulting in a deficit of one peer. To date, all three existing peers have participated in a QI review for FY23-24. However, agency will need to send a representative to the next QI Peer Reviewer training to replace former peer reviewer Ashley Wooten.	No recommendations and/ or corrective actions required.
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 for FY23-24 includes a list of seven additional contracts for FY2023-2024. The list includes: the name of grant, funding source, contract period, and contract amount. Additional funders are: HHS Basic	No recommendations and/ or corrective actions required.

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						Center, Citrus Health– Emergency Beds, Children's Trust, DCF Host Homes, Citrus Health – Seed to For, CDBG Miami Dade County, and United Way of Miami Dade.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for	☐	☐	☐	☒	☐	Documentation – LSF Certificate of Insurance. General Liability is covered 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. 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	No recommendations and/ or corrective actions required.

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medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						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	
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.	No recommendations and/ or corrective actions required.
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with	☐	☐	☒	☐	☐	Documentation: Accounting Procedures Manual.	No recommendations and/ or corrective actions required.

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GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**						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 through March 31,2024. 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. Program code 3100 is designated for Miami Bridge and each transaction is further delineated by program location, Miami, or Homestead.	No recommendations and/ or corrective actions required.
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and	☐	☐	☒	☐	☐	Observation/Documentation:	No recommendations and/ or corrective actions required.

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allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**						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 Custodian requests 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 detailed 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 October 2023-March 2024. 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.	No recommendations and/ or corrective actions required.
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS funds since the last time on-site.	No recommendations and/ or corrective actions required.

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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 Deposit Recap 3rd (July-September 2023) and 4th (October – December) quarters were reviewed. 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 third and fourth quarters of the FY demonstrate submission of payroll taxes to be on or before the due dates. Payment of taxes are through electronic funds transfer (EFTs) and confirmation of deposit submission is documented.	No recommendations and/ or corrective actions required.

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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 30, 2023 – March 31, 2024. 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.	No recommendations and/ or corrective actions required.
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 an 11-month period ending May 31, 2023, and year ended June 30, 2022 for the review. The financial year end of Miami Bridge ended May 31. Accordingly, the current financial statements are prepared for eleven months from July 1, 2022 to May 31, 2023. Effective June 1, 2023, these financial statements were consolidated with LSF. The audit was completed by Verdeja, De Armas, Trujillo, and Alvarez (VDTA) Certified Public	No recommendations and/ or corrective actions required.

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						Accountants, and was dated March 25, 2024. Per the auditors, no management letter is required because there were no findings required to be reported in the management letter (Section 10.656 (3)(e), Rules of the Auditor General) for the eleven-month period ended May 31, 2023.	
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.	No recommendations and/ or corrective actions required.

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	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
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**	☐	☐	☒	☐	☐	Documentation. A review of offer letters, and employee personnel action forms was conducted to validate all direct care staff is paid at least $19 per hour.	No recommendations and/ or corrective actions required.

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CONCLUSION

Lutheran Services Florida Miami Bridge Homestead has met the requirements for the CINS/FINS contract as a result of full compliance with 12 of the 12 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the 14 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. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

SUMMARY OF RECOMMENDATIONS

None at the time of the review.

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 Lutheran Services Florida (Miami Bridge - Homestead) Residential Program

Date: April 24-25, 2024

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	Limited
1.03 Incident Reporting	Limited
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Limited
1.07 Outreach Services	Satisfactory

Percent of indicators rated Satisfactory: 57.14 %
Percent of indicators rated Limited: 42.86 %
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	Satisfactory
3.07 Video Surveillance System	Satisfactory

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 89.29 %
Percent of indicators rated Limited: 10.71 %
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
Paula Friedrich – Regional Monitor, Department of Juvenile Justice
Duane Gross – Childrens Home Society West Palm
Nathaly Milla – Florida Keys Children Shelter
LaToya Robinson – Prevention Central

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	1	# Healthcare Staff
X	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer	1	# Other (listed by title): Quality Specialist___
	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	15	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	14	# 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	X	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	X	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

5	# of Youth	4	# 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.

Since the initiation of the plan to merge Miami Bridge with Lutheran Services of Florida in the summer of 2022, the primary objective has been to ensure the provision of top-tier care and services for youth and families in the local area. Guided by its deep-rooted commitment to community, the agency persists in its mission to cultivate resilient youth who can realize their full potential. Concurrently, it works collaboratively to fortify and empower healthy families, recognizing them as the foundational elements of our society. This commitment has driven the agency to enhance its programmatic structure, expand personnel, increase volunteer engagement, intensify outreach initiatives, upgrade the facilities, and fortify relationships with community partners. The staff members create a supportive and nurturing environment, empowering young individuals to devise innovative solutions and strategies for navigating challenges.

The agency provides services to 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 recognized by the Council on Accreditation (COA) and accreditation is effective until August 31, 2025. Once the acquisition is finalized, Miami Bridge will be integrated into LSF's re-accreditation timeline of February 28, 2026. The facility is also licensed through the Department of Children and Families for 20 beds and the current license is effective 4/1/2024. At the time of the Quality Improvement review, the shelter census was 15 youth, ten (10) DCF, four (4) CINS/FINS, and one (1) Domestic Violence respite.

The following programmatic updates were provided by the agency:

Staffing

Throughout the assessment period, guided by the Program Director, Jose Fontanez, the CINS/FINS operations have welcomed 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.

The agency experienced a departure in the Clinical Director’s position in December 2023. It expeditiously sought to fill the vacancy by hiring Arlette Parrado in January 2024. In her capacity as Clinical Director, Mrs. Parrado, a licensed clinical social worker, has played 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.

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.

Samantha Roberts continues to fulfill her role as Shelter Manager at Miami Bridge bringing forth consistent leadership, maintaining work environment and improving the quality of services provided to shelter beneficiaries. In February 2024, Ms. Roberts transferred back to Homestead shelter from the Central shelter due to the resignation of Sabrina Valentin (former Homestead shelter manager).

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.

Additionally, Miami Bridge continues to foster a robust partnership with Miami-Dade County public schools, particularly in handling truancy referrals.

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, 2024 (Homestead) and June 1, 2024 (Central).

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 Miami shelter is in the process of renovating the boy's dorm to semi-private rooms. Target date for dorm completion is June 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. The Homestead shelter is currently under a renovation proposal to upgrade all exterior property lights and inside shelter lighting.

Funding/Finance

The agency finalized an award 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
Until the official merger of Miami Bridge with Lutheran Services of Florida, board structure will remain the same. Community engagements have included over 40 events during current contract year.

Major Challenges
The challenges of maintaining appropriate Youth Care Specialists levels resulted in merging the youth in Miami back into the Homestead site at the end of November 2023 until January 2024. During this period, the staffing levels were brought up to par and the Miami location was able to reopen towards the end of January 2024.

Narrative Summary
LSF Miami Bridge Homestead 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, a fulltime nurse, and a senior administrative assistant (HR). The program is also supported by an intake referral specialist and a data entry clerk.

At present, the program has 21 Youth Care Specialists assigned to the Homestead shelter 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. The increased hires in Homestead are a result of ensuring appropriate staffing levels as the majority of resignations have been at that site.

The case manager assigned to Homestead shelter decided to move into a Youth Care Specialist position in March 2024 while the case manager in Central resigned in April 2024. In addition, the program has experienced resignations from multiple Youth Care Specialists since the last QI review among additional resignations in the residential counselor positions. The residential counselor positions (Homestead:1 and Miami:2) have tendered offers to new applicants with starting dates within the next few weeks. There are pending interviews to fill the second residential counselor position in Homestead.

Guided by the new Clinical Director, the community counseling services at Homestead is overseen by a team of three counselors. At this time, two of the three community counseling positions are vacant. The LSF recruitment department has put a high priority in identifying potential applicants to fill all vacancies.

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 **Satisfactory with Exception**, Indicator 1.02 Provision of an Abuse Free Environment was rated **Limited**, 1.03 Incident Reporting was rated **Limited**, Indicator 1.04 Training Requirements was rated **Satisfactory,** Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory with Exception,** Indicator 1.06 Client Transportation was rated **Limited**, and Indicator 1.07 Outreach Services was rated **Satisfactory**.

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

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

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

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

Standard 1:

Indicator 1.02 - Limited

Nine of the 12 abuse hotline calls for residential youth were not documented in the program's electronic logbook. It appears the residential counselors were not entering hotline calls related to allegations for residential youth in the program's logbook.

Grievance box checks were missed and/or not documented in the logbook for 31 of the 60 days reviewed. Two of the 35 grievances [2/14 (resolved 2/29) and 4/10 (resolved 4/15)] were not resolved within 72 hours.

Indicator 1.03 - Limited

Four internal incident reports indicated within the report itself that the incident was not called into the CCC within two hours of the incident. It could not be determined when one incident was reported to the CCC as the internal report indicated the CCC was contact at the exact time the youth altercation took place and there was no documentation of the call being made to the CCC in the logbook. The last reviewed incident report indicated the incident had been reported to the CCC within two hours; however the incident report did not include the CCC report number and the call was not documented in the logbook on that date.

The four CCC incidents documented in the logbook listed a different time of reporting than was documented in the SharePoint system. Three of nine reviewed internal incident reports documented the incident with an incorrect incident type description. (One was entered as Staff Health or Mental Health/Substance Abuse complaint was actually a youth verbal threat incident; one was entered as "youth injury" but the incident was actually a youth altercation with no injury documented, one was listed as "Staff health/mental health/substance abuse services complaint but the incident was a youth threatening other youth). Five of the nine reviewed internal incident reports recorded a call to the CCC to report the incident which was not documented in the program's electronic logbook, as required.

Indicator 1.06 - Limited

A search for single rider transportation in the electronic logbook led reviewer to several single transportation events which were not approved by the supervisor. A similar finding was also observed on the all transport logs where single transports were conducted but not flagged as single transports or documented supervisor's approval. For example, in the month of November 2023, seven apparent single youth transports to school only listed the youth's name but not the vehicle used or staff driving youth. These were noted as "transport to school". Another 10 of these events were identified in December 2023 and 18 in March 2024.

Transportation logs reviewed did not consistently reference which van is used at the time of transport making it difficult to monitor usage based on mileage. Other information that is often omitted from the entries include name of driver, number of youth (based on names/ID numbers of youth), mileage, and location.

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, explaining how finding(s) are determined.	**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: 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: 15 new hire files
Total number of 5 Year Re-screen Employee Files: 0 rescreened staff
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, Email sent to BSU for confirmation of receipt of Annual Affidavit.

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Exception**	The program implemented the use of the Predictive Index (PI) pre-employment assessment in September 2023. A total of 15 staff were hired since the last QI review for LSF Miami Bridge Homestead. Three of the 15 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 remaining 12 staff who completed the PI assessment received passing scores of 7 or more on a scale of 10.	Three 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.
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**	All twelve staff who completed the PI assessment received passing scores.	

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. *(Employees who have had a break in service and are in good standing may be reemployed with the same agency without background screening if the break is less than 90 days.)*	**Compliance**	Background screenings for 15 new hires were initiated prior to hire 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 the date of the last screening or prior to retained fingerprints expiration date.	**No eligible items for review**	The program did not have any employees who met the criteria for re-screening during the review period.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The program emailed its Annual Affidavit of Compliance with Level 2 Screening Standards to the Background Screening Unit on January 5, 2024, prior to the January 31st deadline.	
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 15 new hires.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Limited**
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 and 1.02.01 - Grievance Process, that were 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 outlines the agency's behavioral expectations for staff and 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 which is maintained 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 12 abuse calls were accepted by the hotline for residential youth. None of the calls were institutional. The calls were completely documented on the abuse reporting form for all 12 calls. Three of the 12 abuse hotline calls for residential youth were documented in the program logbook. Community based hotline calls are entered in the agency's SharePoint database; however, no community based hotline calls were reported for the review period.	Nine of the 12 abuse hotline calls for residential youth were not documented in the program's electronic logbook. It appears the residential counselors were not entering hotline calls related to allegations for residential youth in the program's logbook.
Youth were informed of the Abuse and Contact Number	**Compliance**	Postings of the Abuse Hotline Number were 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. Five youth surveyed indicated knowledge of the abuse hotline number.	
Grievance			
The program must have an accessible and responsive grievance process for youth to provide feedback and address complaints. Program director/ supervisor will have access to and manage grievances unless it is towards themselves.	**Compliance**	The program has an accessible grievance process that is outlined in policy 1.02.01. Youth are informed of the grievance process during admission and receive a copy of the youth handbook that includes the procedures.	
<u>Shelter only:</u> Grievances are maintained on file at minimum for 1 year.	**Compliance**	The shelter manager maintains a file of grievances for at least one year.	
<u>Shelter only:</u> 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 shelter manager and shift lead have the keys to the grievance box. The grievance box was observed to be mounted on a wall adjacent to the youth lounge and forms are accessible at the same location.	

Shelter only: 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 the following randomly selected 2-week periods: November 4-15; December 9-20; January 20-31; February 3-14; March 10-21, and April 7-18 for a total of 60 days. Grievance box checks documented in the logbook were evident for only 29 of the 60 days reviewed.	Grievance box checks were missed and/or not documented in the logbook for 31 of the 60 days reviewed.
Shelter only: All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly.	**Exception**	A total of 35 grievances were reported. Thirty-three of the 35 grievances reviewed were resolved within 72 hours.	Two of the 35 grievances [2/14 (resolved 2/29) and 4/10 (resolved 4/15)] were not resolved within 72 hours.
1.03: Incident Reporting			**Limited**
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**	The program documents all incidents, both reportable and non-reportable, in the electronic SharePoint system. The program had a total of 15 incidents which were reported to the CCC, including four contraband incidents, two youth-on-youth sexual contact, two youth battery incidents, one baker act, one other agency investigation, and three complaints against staff including one sexual misconduct and one use of intoxicating substances. A sample of nine (9) of the 15 CCC incidents were reviewed for reporting timeframes and documentation. Three of nine reviewed internal incident reports appear to have been reported to the CCC within two hours, as required.	Four internal incident reports indicated within the report itself that the incident was not called into the CCC within two hours of the incident. It could not be determined when one incident was reported to the CCC as the internal report indicated the CCC was contacted at the exact time the youth altercation took place and there was no documentation of the call being made to the CCC in the logbook. The last reviewed incident report indicated the incident had been reported to the CCC within two hours; however the incident report did not include the CCC report number and the call was not documented in the logbook on that date.
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	All nine CCC reports reviewed 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 SharePoint System which 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 reviewed were recorded in the SharePoint system.	
Incidents are documented in the program logs and on incident reporting forms	**Exception**	Four of the nine internal incident reports reviewed documented the CCC was contacted to report the incident in the program's electronic logbook.	The four CCC incidents documented in the logbook listed a different time of reporting than was documented in the SharePoint system. Three of nine reviewed internal incident reports documented the incident with an incorrect incident type description. (One was entered as Staff Health or Mental Health/Substance Abuse complaint was actually a youth verbal threat incident; one was entered as "youth injury" but the incident was actually a youth altercation with no injury documented, one was listed as "Staff health/mental health/substance abuse services complaint but the incident was a youth threatening other youth). Five of the nine CCC incidents reviewed were not documented in the program's electronic logbook, as required.
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	All nine incident reports recorded in the Share 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**
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 reviewed indicated the United States Department of Justice (DOJ) Civil Rights & Federal Funds training was completed 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 reviewed verified each staff completed a minimum of 80 hours, ranging from 88-117 training hours.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Compliance**	All four new hire training files reviewed demonstrated staff completed all mandatory training during the first 90 days of employment.	

CINS/FINS QUALITY IMPROVEMENT TOOL			
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 community counseling 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 community counseling case manager was hired 7/13/2023 and still has time within the first year to complete the FL Statute 984 CINS Petition 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**	The program has not hired a non-licensed mental health clinical staff during the review period.	
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).*	**Compliance**	A review of four in-service training records found that all four staff members completed all of the required Florida Network, SkillPro, and job-related training hours. Although, there are some annual trainings missing, staff have time to complete them until 07/02/2024.	
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 with Exception**
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, Associate VP of Quality Assurance **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	**Exception**	Most recent chart review for the current FY was completed during the first quarter on September 20, 2023. The tool was not updated to conduct a second quarter review of files but a corrective action was implemented by the QA Specialist to include development of new tool, update process, and conduct training. The agency recently hired a QA Support Coordinator to assist with case record reviews in addition to local program peer reviews. A sampling table will be used to determine the number of records to be reviewed for April-June and 70% of those will be reviewed by the QA Support Coordinator and 30% by the local program staff. Each program will conduct 100% of sampling records quarterly and a report will be generated to reflect findings and corrective actions.	Record reviews were not conducted after the first quarter of the FY because the program halted reviews to revise the tool to include NIRVANA assessment questions.

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 SharePoint 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 79 incidents/accidents were reported for the period November 2023-April 15, 2024. 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 demonstrates a monthly review of the statewide End-of-Month ("EOM") report generated by the Florida Network Office. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures.	**Compliance**	EOM reports are emailed to the Program Director and disseminated to the management team. Data from the EOM report is reviewed at the monthly CQI meetings. Monthly CQI meeting agendas and minutes for the review period validates program review of the EOM reports on a regular basis with key staff namely, Intake Coordinator, Clinical Director, A Specialist, Shelter Manager, and HR Administrative Assistant.	
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 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 program performance is routinely reviewed with the Board of Directors. 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. In addition, Miami Bridge has a local advisory board that meets regularly. The most recent meeting held 3/5/2024 included a discussion the agency's performance with contractual requirements.	
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			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**NO**	
		If NO, explain here: 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
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 42 authorized drivers and per the program director, all staff 42 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 valid driver's license checks were provided for all 42 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.	**Exception**	Agency maintains an electronic logbook, which staff uses to keep track of every clients' transport as well as an app called Rastrack. Reviewer obtained reports from the last six months (November 2023-April 2024) which calculated a total of 60 single rider transport approved by supervisor. Reports were also provided for all other transport events for the same period. A review was conducted of the all transport logs to determine whether or not every single transport was flagged as such and included supervisor's approval.	A search for single rider transportation in the electronic logbook led reviewer to several single transportation events which were not approved by the supervisor. A similar finding was also observed on the all transport logs where single transports were conducted but not flagged as single transports or documented supervisor's approval. For example, in the month of November 2023, seven apparent single youth transports to school only listed the youth's name but not the vehicle used or staff driving youth. These were noted as "transport to school". Another 10 of these events were identified in December 2023 and 18 in March 2024.

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.	**Exception**	One week of each month November 2023 until April 2024 was randomly selected and reviewed. Transportation activities are noted in the electronic logbook and a specific icon of a vehicle is used to distinguish transportation events. The program uses two Homestead vans to transport youth and sometimes will transport youth using the Central shelter van.	Transportation logs reviewed did not consistently reference which van is used at the time of transport making it difficult to monitor usage based on mileage. Other information that is often omitted from the entries include name of driver, number of youth (based on names/ID numbers of youth), mileage, 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):Shelter Director
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 Shelter Director is the staff assigned on all local DJJ board, circuit and council meetings. Director provided agenda and follow-up e-mails, which confirmed attendance to all events.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	Program maintains agreements with other community partners. Agreements include different types of services provided and referral process for each agency shelter works with.	
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**	Program maintains documentation of outreach activities in a binder and in chronological order. All outreach activities are entered into NetMIS with dates, duration, location and number of people participating on each event.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	Staff responsible to do outreach includes the Community Base Counselors, Shelter's Director, and Shelter Supervisors. These duties are included on their job descriptions.	
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 2.01, titled Screening and Intake, 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.*			
Total number of Open (Residential & Community) Files: 2 open residential, 2 open community counseling **Total number of Closed (Residential & Community) Files: 3 closed residential, 3 closed community counseling** **Staff Position(s) Interviewed** *(No Staff Names)* **: Intake Coordinator** **Type of Documentation(s) Reviewed: Case record on Lauris Online**			
Shelter youth: Eligibility screening form 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 form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	All five 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 ten 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**	Nine of the ten 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. One record noted in the file that the parent is in Guatemala, and the guardian (aunt) refused to participate. Consequently, some dates and consents were not signed.	
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 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 correctly assessed as required if needed.	**Compliance**	All ten youth files reviewed demonstrated during intake, all youth were screened for suicidality and five 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 with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The agency has the required policy and procedure 2.02, titled Network Inventory of Risks, Victories, and Needs Assessment, which 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.*			
Total number of Open (Residential & Community) Files: 2 open residential, 2 open community counseling **Total number of Closed (Residential & Community) Files: 3 closed residential, 3 closed community counseling** **Staff Position(s) Interviewed (No Staff Names): Intake Coordinator** **Type of Documentation(s) Reviewed: Case record on Lauris Online**			
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**	All five community counseling files reviewed demonstrated NIRVANA was initiated at intake and completed within two to three face-to-face contacts after the initial intake.	

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.	**Exception**	Eight of the ten youth files reviewed included a supervisor's signature on the completed NIRVANA assessments.	Two youth two charts, one residential and one community counseling, did not include a signature from a supervisor on the 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-Assessments were 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**	The NIRVANA Post-Assessment was completed at discharge for on applicable youth who had a length of stay greater than 30 days in the youth file.	
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**	Nine of the ten files included the NIRVANA interview guide and/or a printed NIRVANA for each Lauris online youth record. The NIRVANA was in Lauris for one of the files but he staff was able to print the completed assessment from NetMIS.	
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 2.03, titled Cas/Service Plan, and needs assessment, which 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.*			
Total number of Open (Residential & Community) Files: 2 open residential, 2 open community counseling **Total number of Closed (Residential & Community) Files: 3 closed residential, 3 closed community counseling** **Staff Position(s) Interviewed (No Staff Names): Intake Coordinator** **Type of Documentation(s) Reviewed: Case record on Lauris Online**			
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**	All ten 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.	

Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	Nine of the ten files demonstrated case/Service plan is developed within seven working days of NIRVANA.	One case plan for a residential youth was not developed within 7 working days of the completion of the Nirvana. The youth was transferred to CINS/FINS on 4/10/2024 and case plan was not initiated until 4/17/2024.
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 ten files reviewed demonstrated individualized and prioritized need(s) and goal(s) identified by the NIRVANA, service type, location, person(s) responsible, signature of counselor and target date(s) for completion, and date the plan was initiated. Youth signatures were not present in three of the records reviewed, and parent/guardian signatures were missing from six files. However, the case notes clearly indicated the parent/youth participated.	One community counseling case plan was missing the frequency of services for the six goals listed. Two shelters and one community counseling youth case plan did not include actual completed dates for goals. The supervisor's signature was missing on one shelter and one community counseling case plan.
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**	Five community counseling records were in service for over 30 days. Service plan reviews were conducted timely as required in all five records.	
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 2.04, titled Case Management and Service Delivery, which 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.*			
Total number of Open (Residential & Community) Files: 2 open residential, 2 open community counseling **Total number of Closed (Residential & Community) Files: 3 closed residential, 3 closed community counseling** **Staff Position(s) Interviewed (No Staff Names): Intake Coordinator** **Type of Documentation(s) Reviewed: Case record on Lauris Online**			
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 progress of 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 post discharge 12. Provides follow-up after 60 days post discharge	**Compliance**	All ten records reviewed demonstrated coordination of service plan implementation based on the youth's/family's problems and needs. It was also evident the case worker monitored youth's/family's progress in services, provided support for families when needed, and referred the youth/family for additional services when appropriate, Thirty and 60 day follow ups were completed timely in two 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 with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: The agency has the required policy and procedure 2.05, titled Counseling Service, which 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.*			
Total number of Open (Residential & Community) Files: 2 open residential, 2 open community counseling **Total number of Closed (Residential & Community) Files: 3 closed residential, 3 closed community counseling** **Staff Position(s) Interviewed (No Staff Names): Intake Coordinator** **Type of Documentation(s) Reviewed: Case record on Lauris Online**			
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	**Exception**	Provision of group sessions was reviewed during the review period for the following randomly selected weeks: November 13–17; December 10–16; January 21–27; February 12–16; March 4–8; and April 8–12. Groups held for five of the six weeks reviewed.	During the week of January 21 to 27, groups were not conducted for two of the five days.
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**	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 five 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			
There is evidence the program completes review of 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 youth records created in Lauris online with adherence to all laws regarding confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	Case notes are maintained in all of the records 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.	
When an intake is conducted through virtual means, consent is confirmed by the counselor, documented in the file, and reviewed with the supervisor during supervision/case review. There is written documentation provided in the youths file for reasons why virtual sessions are in the best interest of the youth and family.	**No eligible items for review**	None of the intakes for the records reviewed were conducted through virtual means.	
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 2.06, titled Adjudication/Petition Process, which 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.*

Total number of Open (Residential & Community) Files: 1 open community counseling youth record
Type of Documentation(s) Reviewed: Case record on Lauris Online

Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	One applicable case staffing was held during the review period. Per the meeting sign in sheet, participants included a DJJ representative, the CINS/FINS provider staff, and a local school district representative.	
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	**No eligible items for review**	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. No additional members were requested to be present.	
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	**Compliance**	As a result of the case staffing, the youth and family were provided a revised case plan.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**Compliance**	A written report was provided to the parent/guardian at the end of the meeting outlining the recommendations of the committee	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	Court intervention was not required for the case staffed.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	Court intervention was not required for the case staffed.	

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 2.07, titled Youth Records, which 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 Specialist **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 clearly 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 staff have their own username and passwords.	
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, 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 with Exception**
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			
Staff Position(s) Interviewed *(No Staff Names)* **: Program 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)* **: Program 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. Documentation in the youth's file showed the youth 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	**Exception**	The case plan for two of the three youth reflected goals for anger management and family coping skills.	One of 3 youth did not have a case plan developed for the DV stay from 3/20-4/9/24. Youth was transferred to CINS/FINS on 4/10 and case plan was not initiated until 4/17/24.
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): Program 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): Program 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): Program 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**		
There is evidence of the completed TOPSE is completed by the caregiver (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 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 3.01- Shelter Environment, 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: 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**	During the facility walk through, all furnishings were observed to be in good repair. The interior of the facility was free of insect infestation and the exterior of the building which is surrounding by large trees is maintained well. Both the parking lot and basketball court were free of hazard. A large dumpster is located near the exit of gate of the campus and was observed to be covered during the visit. Youth have access to a bathrooms in each dorm equipped with three showers, dressing rooms, and three toilet stalls, and vanity area with sinks. Doors are secure with key access required. There are three sets of keys per shift for staff to use in addition to a set kept by the program director, nurse, and counseling staff. Program has postings located in the counseling hallway and in each dorm that includes abuse and CCC hotline information, rights and responsibilities, and program rules. SOGIE signage and egress plans was observed throughout the facility. The program schedules are posted on an office window adjacent to the youth lounge.	
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**	All doors to staff and agency vehicles were locked and secure when checked. The program uses two minivans to transport youth. Both vehicles are equipped with first aid kits, fire extinguishers, glass breaker, flashlights, and seat belt 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.	**Compliance**	Chemicals are stored in a locked closet adjacent to the kitchen. A perpetual inventory is the primary means of maintaining the current and real-time inventory and has been done weekly during the past 6 months. The provider utilizes a chemical dispensation system that is mounted in the chemical closet and dispenses a specific ratio of concentrated professional cleaning chemicals with water into an appropriate container to create a ready-to-use product. MSDS are maintained on each item.	
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**	The facility has a laundry room furnished with two washers and two dryers. No excessive lint was observed in the dryers during the tour. DCF license is issued by Department of Children and Families for 20 beds with an effective of April 1, 2024 and a copy is on file with reviewer. The program has dormitory style rooming and both the boys and girls dorm rooms were well maintained, did not contain contraband, and were free from graffiti. Youth are assigned individual beds and lockers that are kept locked, to keep personal belongings. All beds had a pillow and were covered with bed sheets and a comforter.	
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 on each shift monthly (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**	The annual facility fire inspection was conducted by Miami Dade Fire Rescue Department on 2/26/2024 and resulted in a satisfactory inspection. The facility is in compliance with local fire safety guidelines. Fire Drills & Emergency Drills were reviewed for the past six months. Fire Drills were completed monthly from January 2024 to April 2024 on first and third shifts, while the second shift had completed Fire Drills for January, February and April 2024. Annual Fire extinguisher inspection was completed in 12/2023 by City Fire Inc. for 14 facility and two vehicle fire extinguishers. City Fire also conducted the annual fire suppression system inspection in 4/2024.	Agency is unable to provide Fire Drills and Emergency Drills for the months of November and December 2023. Second Shift is missing a Fire Drill for the month of March 2024.
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.	**Compliance**	The kitchen is equipped with two commercial refrigerators and one freezer; refrigerator temperatures were optimal at 34 degrees Fahrenheit and the freezer's temperature was -1 degrees Fahrenheit. A satisfactory combined Department of Health (DOH) Group Care and Food inspection was completed 1/18/2024 with no violations noted. Food menus posted in the kitchen are current and are signed by a Licensed Dietician, and expire on 3/1/2025.	
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**	The youth are engaged in meaningful, structured activities seven days a week during awake hours and idle time is minimal as evidenced by the daily schedule of activities provided. The program has a weekday and weekend schedule with structured activities each day. Physical activity is scheduled for at least 1 hour daily. Youth are provided an opportunity to attend religious/faith based activities three times a week and alternate activities are planned for youth who do not choose to participate in faith-based activities. Youth are given the time and opportunity to do homework and read daily. The program schedule is posted in the dayroom and is accessible to both youth and staff.	
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 Open Files: 2 open residential **Total number of Closed Files: 3 closed residential** **Type of Documentation(s) Reviewed: Youth Case Files**			
Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	After review of five files (two Open/three Closed) all depicted that they received a comprehensive orientation and handbook 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 five files reviewed depicted that the initial orientation included all of the areas listed "A thru J", and were checked off/initialed by youth and staff member, as well as signatures of both staff and client were provided.	
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**	All five files reviewed showed that each component of orientation, including topics and dates of presentation were documented, along with youth and staff signatures.	
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 Open Files: 2 open residential
Total number of Closed Files: 3 closed residential
Type of Documentation(s) Reviewed: Youth Case Files

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 five files indicated that an alert was immediately entered into the programs alert system when the youths were admitted.	
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: Select two consecutive weeks for each month, November – April, for a total of six, 2-week periods **Use same sample for review of grievance box checks and supervisory review of logbooks.** **Type of Documentation(s) Reviewed: Electronic Logbook**			
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	Review of the electronic logbook entries showed entries that impact the security and safety of the youth and/or program were highlighted and/or was depicted in a different color font.	
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**	Review of the electronic logbook revealed that the program director or designee reviewed the entries on a regular basis (minimum of once every week) and made notes indicating the dates reviewed and provided corrections, recommendations and/or follow-ups where needed with a signed/dated entry.	
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 Nov 2023 - April 2024.	
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" 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			**Satisfactory**
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: March 29th , 12am-2am, April 3rd , 2am-4am, April 7th , 4am-6am, April 13th , 1am-3am, April 22nd , 3am-5am **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Supervisor** **Type of Documentation(s) Reviewed: Logbook Entries / Video Surveillance** **Describe any Observations: Surveillance System**			
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	**Compliance**	Staff schedules for November 2023 - April 2024 showed at least two staff on all shifts.	
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 maintained in 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. 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	**Compliance**	Bed check dates/times randomly selected are as follows: •March 29th , 12am-2am •April 3rd , 2am-4am •April 7th , 4am-6am •April 13th , 1am-3am •April 22nd , 3am-5am After review of bed checks with corresponding video surveillance during five pre-selected - two hour blocks during the overnight shift - All bed checks were completed in real time on both the boys and girls wings. There's a minimum of two staff on each shift.	
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: March 29th , 12am-2am, April 3rd , 2am-4am, April 7th , 4am-6am, April 13th , 1am-3am, April 22nd , 3am-5am **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Supervisor** **Type of Documentation(s) Reviewed: Video Surveillance Cameras** **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 (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit; to include locations where youth searches are conducted. 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. Camera views are clear. 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.	**Exception**	After review of the agency's electronic logbook it shows that the Program Supervisor or Designee conducts supervisory reviews of the video surveillance system.	Supervisory reviews of the Video Surveillance System from November 1, 2023 to April 22, 2024 revealed three deficiencies exceeding 14 day reviews during the following timelines: 1. 1/18/24 - 2/2/24 (15 days) 2. 2/6/24 - 2/25/24 (19 days) 3. 3/12/24 - 4/15/24 (34 days) - *Note: There was a 34 day lapse with checks between 3/12/24 to 4/15/24 - Due to resignation of Shelter Manager and taking over of current Shelter Manager.
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	**No eligible items for review**	There were no reported instances where the camera services were malfunctioning and in need of repairs during the review period.	
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:		
	Agency Policy 4.01 Healthcare Admission Screening was last reviewed on 5/1/23.		
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 Files: 2 open residential files **Total number of Closed Files: 3 closed residential files** **Type of Documentation(s) Reviewed: policy and procedures, physical healthcare admission screening**			
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**	All youth files reviewed reflected that a review of Health Care Admissions Screening/Intakes was completed by the Nurse or designated intake youth care staff. One of five reviewed records was applicable for the youth currently receiving prescribed medication, one youth was identified with allergies, and one had a recent injury or illness however, the intake form did not explain the observed injury as required by the intake form. One youth was prescribed mental health medication at the time of her intake at the program.	
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.)	**No eligible items for review**	None of the reviewed records were applicable for a youth with a chronic medical condition.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**No eligible items for review**	None of the reviewed records were applicable for a youth requiring a follow-up medical appointment.	
All medical referrals are documented on a daily log.	**No eligible items for review**	None of the reviewed records were applicable for a youth with a medical referral.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed.	**Compliance**	The program maintains a policy, procedure and process for referring youth for follow-up medical care as required.	
Additional Comments: **There are no additional comments for this indicator.**			

4.02 - Suicide Prevention			Satisfactory
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 Open (Residential & Community) Files: 1 open residential file **Total number of Closed (Residential & Community) Files: 2 closed residential and 3 closed community counseling files** **Type of Documentation(s) Reviewed: policy and procedures, intake forms including suicide risk screening, Lauris system youth records,**			
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 supported 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.	**Compliance**	Documentation verified an assessment of suicide risk (ASR) was completed for all three residential youth who were placed on the appropriate level supervision based on the result of the suicide risk assessment.	
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	**Compliance**	Staff person(s) assigned to monitor the youth documented his/her observations of the youth's behavior at 30 minutes or less intervals using a precautionary observation (PO) log.	
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.	**Compliance**	Precautionary observation documentation included time of day, behavioral observations, any warning signs observed and the observer's' initials. Documentation was reviewed by supervisory staff each shift.	
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 all three records reviewed, 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.	**Compliance**	All three residential youth record reviewed provided evidence on each shift that supervisory staff reviewed the observation logs. Completed observation logs are stored in the youth's electronic Lauris online record.	
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.	**No eligible items for review**	None of the three community counseling records reviewed were immediately assessed by a licensed professional as the program's policy and procedures require the program to refer youth to a qualified mental health professional or service provider if the initial assessment indicates a need for father assessment or treatment.	
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.	**Exception**	Reviewed records of community counseling youth who scored as at risk of suicide on the intake form did not include documentation of a referral having being made. The program's practice was to use electronic chat to communicate the need for mental health staff to complete an assessment of suicide risk (ASR) for any youth scoring for risk on the intake assessment. All three applicable intakes were missing a Behavioral Contract (Safety agreement).	Referrals to a licensed professional or appropriate provider to complete an assessment of suicide risk (ASR) were not evident for the three community counseling youth who scored as at risk of suicide.
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 supported resources available in the community were provided to the parent/guardian of the three youth, 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.	**No eligible items for review**	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.	**No eligible items for review**	The screening for all three community counseling youth records reviewed indicated the intake/screening was not completed at school or during school hours.	
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 Open Files: 1 open file **Total number of Closed Files: 2 closed files** **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.	
The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication: a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse b. Evidence demonstrating their competency to assist with self-administration of medication distribution c. Maintenance of their annual medication training re-certification	**Compliance**	The program maintains a list of staff who are authorized to distribute medication. Documentation showed all the program staff are trained on medication management, and have access to secured and all medications. Three new staff training records supported new staff receive medication training by the nurse.	
The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess: a. strategies implemented to reduce medication errors shelter wide b. analyze factors that contributed to medication errors c. allow staff the opportunity to practice and role-play solutions	**Compliance**	A review of the program's staff meetings agenda and minutes for the past six months indicated medication practice and staff performance is reviewed at each staff meeting.	

The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	Strategies used for ensuring the 2-hour timeframe include having a posted daily schedule for medication administration which makes clear the schedule throughout the day for administering medications with unusual administration times highlighted in color. Additionally the program utilizes electronic reminders on cell phones providing audible and visual reminders for administering medications especially those which are to be administered off of the regularly scheduled medication pass times. Medication times are posted for easy staff reference.	
All non-licensed staff members are clearly identified and designated on the staff schedule and shift change report/shift responsibility form for assisting with the self-administration of medications on each shift	**Compliance**	The program's registered nurse maintains an up-to-date list of staff who have completed the required training and are permitted to assist with medication distribution. These staff are also delineated on the staff schedule.	
The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.	**Compliance**	The agency uses its alert process to communicate medication alert to staff. This process includes using a alert board and alert sheet in each youth record that indicates medication, times, and dosages. If there are any medication updates each shift is notified during shift exchange.	
The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy and the agency has an internal quality assurance process to include the following: a. to ensure appropriate medication management and distribution methods b. to track medication errors c. to identify systemic issues and implement mitigation strategies, as appropriate.	**Compliance**	The delivery process of medication is consistent with The Florida Network of Youth and Family Services (FNYFS) medication management and distribution policy. 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.	
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			
a. Upon admission, the youth and parent/guardian (if available) were interviewed by the Registered Nurse (when on-site) about the youth's current medications as part of the Medical and Mental Health Assessment screening process and/or an interview was conducted by the RN within three (3) business days if the RN was not on the premise at admission. **If the agency does not have a RN, there was a medication review conducted by a certified Leadership position.* b. Upon intake/admission, there is evidence that the on-shift certified supervisor of higher level staff did review all medication forms by the next business day.	**Compliance**	During intake, when the nurse is on duty, the nurse meets with the youth and guardian, if present. When the nurse is not duty the youth's medical records are reviewed by the nurse within three business days. Medication forms are also reviewed by the shift lead/supervisor during intake.	
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 PANEL- RIGHT TALL CABINET LOCK- RIGHT	**Compliance**	Pyxis machine is stored securely inside the medical office that is kept locked. 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. Narcotics and controlled medications are also stored in the Pyxis station in cubes designated for each youth on medication. 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 ALWAYS conducted by the nurse or when the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication. f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse	**Compliance**	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 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 residential youth records were reviewed. There were no instances found of youth missing their medication or delivery time exceeding the required timeframe.	
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 residential youth records were reviewed. There were no instances found of youth missing their medication due to failure to open the Pyxis machine.	
If applicable: Any staff member deemed responsible for a medication error, there was evidence that the staff member received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. There is evidence that any staff member deemed responsible for 3 errors within a 1-year time frame, had their certification suspended and was not recertified until the completion of the full **in-person** medication administration training, demonstrating competency and re-certification from an RN.	**Compliance**	Staff who were responsible for medication errors were re-trained by the program nurse with supporting documentation to evidence re-training. All staff demonstrate competency and there were no suspension of medication delivery privileges.	
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 and inventoried weekly c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Compliance**	Controlled substances and over the counter medication is stored in the Pyxis machine. Documentation indicated controlled substances are 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 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 4.05 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.*			
Total number of Open Files: 2 open file **Total number of Closed Files: 3 closed files** **Staff Position(s) Interviewed (No Staff Names): Registered nurse** **Type of Documentation(s) Reviewed: youth records** **Observation: Alert board**			
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	All five 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 is in the kitchen which includes a list of youth who have an allergy or other kind of nutritional alert.	

Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	An informal interview with the program's nurse 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.	
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			
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.*			
Total number of Closed Files: 3 closed files **Staff Position(s) Interviewed (No Staff Names): Registered nurse** **Type of Documentation(s) Reviewed: episodic care log, logbooks, knife for life, first aid kit**			
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 had no DJJ CINS/FINS youth who were transported off-site for medical care during the review period.	
All staff are trained on emergency medical procedures	**Compliance**	The program staff are trained on emergency medical procedures by the program's nurse.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	The program maintains five Knife-for-life instruments and six first aid kits. All were observed during the program tour.	
Additional Comments: **There are no additional comments for this indicator.**			