Florida Network for Youth and Family Services
Compliance Monitoring Report for

LUTHERAN SERVICES FLORIDA – MIAMI BRIDGE (CENTRAL)

2810 NW South River Drive
Miami, Fl. 33125

October 23-24, 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 Lutheran Services Florida Miami Bridge (LSF Miami Bridge) Central for the FY 2024-2025 at its program office located at 2810 NW South River Drive, Miami, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. LSF Miami Bridge is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance, and are funded with General Revenue Funds effective from July 2024 through June 30, 2025.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC and Peer Reviewers Wendy Pierre-McNealy – Florida Network of Youth and Family Services; Kayla N. Clark, Florida Keys Children's Shelter; Fern Ellenwood, Safe Children Coalition Sarasota Youth Shelter; and Tametria Hall, Urban League of Palm Beach. Agency representatives from LSF Miami Bridge Central present for the entrance interview were: Samantha Roberts, Shelter Manager Central; Alex Browne, Shelter Manager Homestead; Tracy Scott, Registered Nurse; and Lashonda Chavis, Intake Coordinator. The last onsite QI visit was conducted December 6-7, 2023.

In general, the Reviewer found that LSF Miami Bridge Central is in compliance with specific contract requirements. **LSF Miami Bridge Central received an overall compliance rating of 100% for achieving full compliance with 12 applicable indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions or recommendations made as a result of the monitoring visit.

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

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 10-23-2024-2025

Agency Name: Lutheran Services Florida Miami Bridge (Central)	Monitor Name: Marcia Tavares, Lead Reviewer
Contract Type: CINS/FINS	Region/Office: 2810 NW South River Drive, Miami, Fl 33125
Service Description: Comprehensive Onsite Compliance Monitoring	Site Visit Date(s): October 23-24, 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 Acceptable	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. The agency currently has a total of four current staff members certified as DJJ QI Peer reviewers: Lashonda Chavis, Citizen Fernandez, Jose Ortega, and Samantha Roberts. To date, none of the staff has participated in a QI review but are scheduled to participate in the FY24-25.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: Grant Listing FY23-24. The agency provided a list of five additional contracts for FY2023-2024. The list includes the name of the grant, funding source, contract period, and contract amount.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000	☐	☐	☐	☒	☐	Documentation – LSF Certificate of Insurance. General Liability through Philadelphia Indemnity Company, for limits of coverage of $1,000,000 each $3,000,000 aggregate, and medical expense for $5,000, effective through 12/27/24.	

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Acceptable	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:
policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						Automobile insurance through Philadelphia Indemnity Company for combined single limits for $1,000,000 each accident, effective through 12/27/2024. Workers Compensation through Accident Fund Insurance Company of America with limits of $1,000,000 each/aggregate, effective through 6/01/2025. Umbrella liability through Philadelphia Indemnity Company with limits of $1,000,000 each/aggregate, effective through 12/27/24. Professional Liability Abuse and Molestation through Philadelphia Indemnity Company for $1,000,000 each and $3,000,000 aggregate, effective through 12/27/24. Florida Network is listed as the certificate holder.	

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External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	Interview: During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Accounting Procedures Manual. The 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 FY 24-25. 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	

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	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Acceptable**	**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:
						further delineated by program location, Miami, or Homestead.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Observation/Documentation: Reviewed petty cash Policy and Procedure 4.32 included in section 4 of the Fiscal Manual that was last approved October 5, 2022. The program has a petty cash fund that is used for the shelter. The shelter manager is the custodian of the petty cash which is maintained in a locked box in the manager's office. Petty Cash Custodians request reimbursement of their funds by submitting a Petty Cash Reconciliation Request that includes all original receipts for which reimbursement is being requested along with the 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.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor	☐	☐	☒	☐	☐	Documentation: Reviewed Bank Statements Ameris Bank operating	

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invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation and documentation provided contained 2 signatures. (Disbursements/invoices are approved & monitored by management). **ON SITE**						account and the corresponding bank reconciliations for the period March-August 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.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS funds since the last time on-site.	

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f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Tax Recap 2nd and 3rd quarter. ADP is contracted by LSF to process payroll. ADP is responsible for submitting information for W2s, quarterly 941 reports, and payroll taxes. Tax Recap Ledger Deposit Details for the second and third quarters of 2024 were reviewed. These reports demonstrate submission of payroll taxes be or before the due dates.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided Budget vs. Actual report for the Miami Bridge CINS/FINS Program #304 for the period fiscal year-to-date. 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.	
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	☐	☐	☒	☐	☐	Documentation: The provider submitted a copy of the Financial audit conducted for year ending June 30, 2023 and 2022 for the review. The audit was completed by RSM US, LLP and was dated March 29, 2024. Per	

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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**						the auditors, there was no management letter or deficiency control letter issued as there were no matters required to be reported in these letters.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation reviewed included policy and procedures regarding the following: data back-up contained in the Agency's Policy and Procedure Section 2.10, on Information Management; Section 1, 1.09 Confidentiality of Client Information; 11.09 IT Security; Section 12, 12.01 Access to Case Records; 12.02 Case Record Keeping; 12.07 Risk Prevention and Management; 19.01.27 HIPAA; and 19.03.05 Security of Data and Information Technology.	
j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least $19.00 per hour. This also includes funding for additional staff as approved by the Department. **ON SITE**	☐	☐	☒	☐	☐	Interview and documentation: A review of offer letters and employee personnel action forms was conducted with the Administrative Assistant to validate all direct care staff is paid at least $19 per hour.	

CONCLUSION

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

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Lutheran Services Florida Miami Bridge (Central Miami)
CINS/FINS Program

October 23-24, 2024

Compliance Monitoring Services Provided by

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 71.43 %
Percent of indicators rated Limited: 28.57 %
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	**Limited**
4.03 Medications	**Satisfactory**
4.04 Medical/Mental Health Alert Process	**Satisfactory**
4.05 Episodic/Emergency Care	**Satisfactory**

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 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
Wendy Pierre-McNealy – Florida Network of Youth and Family Services
Fern Ellenwood-Safe Children Coalition Sarasota Youth Shelter
Tametria Hall - Urban League of Palm Beach
Kayla N. Clark – Florida Keys Children's Shelter

Methodology

This review was conducted in accordance with FDJJ-2000 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care/Health Services, and (4) Mental Health/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (Effective July 1, 2024).

Persons Interviewed

	Chief Executive Officer	X	Case Manager	X	Nurse – Full time
	Chief Financial Officer	X	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
	Program Manager		Direct – Care On-Call		# Healthcare Staff
X	Program Coordinator		Intern	1	# Maintenance Personnel
	Clinical Director		Volunteer		# Other (listed by title): ___
	Counselor Licensed	X	Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	X	# Health Records
X	Logbooks		Key Control Log	5	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	14	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	9	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	5	# 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	X	Staff Supervision of Youth
X	Program Activities	X	Tool Inventory and Storage	X	Facility and Grounds
	Recreation	X	Toxic Item Inventory & Storage	X	First Aid Kit(s)
	Searches		Discharge	X	Group
X	Security Video Tapes		Treatment Team Meetings		Meals
X	Social Skill Modeling by Staff		Youth Movement and Counts	X	Signage that all youth welcome
X	Medication Administration	X	Staff Interactions with Youth	X	Census Board

Surveys

6	# of Youth	1	# of Direct Staff		# of Other

Comments

A Quality Improvement Program Review was conducted for FY 2024-2025.

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.

Narrative Summary

Lutheran Services Florida (LSF) Miami Bridge operates the Child in Need of Services and Family in Need of Services (CINS/FINS) program in two Miami locations, North Miami and Homestead, Florida. Effective July 2, 2022, LSF entered into a management service agreement with Miami Bridge and under this agreement the agency will continue to provide services to serve both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at-risk. The agency also provides services to special populations who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Family/Youth Respite Aftercare Services (FYRAC). Miami Bridge is accredited by the Council of Accreditation (COA) through August 31, 2025. In the future, Miami Bridge will be integrated into LSF's re-accreditation timeline of February 28, 2026. The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards. The facility is also licensed through the Department of Children and Families for 20 beds and the current license is effective 6/1/2024.

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 was rated **Limited.**
Indicator 1.02 Provision of an Abuse Free Environment was rated **Satisfactory with Exception.**
Indicator 1.03 Incident Reporting was rated **Satisfactory with Exception.**
Indicator 1.04 Training Requirements was rated **Satisfactory with Exception.**
Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory.**
Indicator 1.06 Client Transportation was rated **Limited.**
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.**
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.**
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 with Exception**.
Indicator 3.05 Behavior Management Strategies was rated **Satisfactory**.
Indicator 3.06 Staffing and Youth Supervision was rated **Satisfactory with Exception**.
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 **Limited**.
Indicator 4.03 Medications was rated **Satisfactory**.
Indicator 4.04 Medical/Mental Health Alert Process was rated **Satisfactory**.
Indicator 4.05 Episodic/Emergency Care was rated **Satisfactory.**

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

Standard 1:
Indicator 1.01 - Limited
1) The agency made an offer of employment to three staff prior to their completion of the pre-employment suitability assessments. One of the three staff did not pass the assessment on the first attempt and received a low score of 2.
2) There's no evidence of one staff re-taking the assessment after receiving a non-passing score.
3) Two of 11 new staff were hired 2-3 weeks prior to the program receiving an eligibility screening from DJJ Background Screening Unit (BSU).

Indicator 1.06 - Limited
1) One of 10 single transports did not document supervisor's approval.
2) Seven of ten single transports did not clearly indicate purpose, and two were missing trip mileage. Two of the transports did not identify the vehicle used.
3) None of the 10 single transports documented evidence of check-ins by phone with the senior program leader or designee upon departure and arrival. This was not a practice overall for any single transports.

Standard 4:
Indicator 4.02 - Limited
1) The logbook observation notes did not contain any supporting evidence regarding the youth's behavior observations or any warning signs as required for the observation.
2) Supervisory reviews were not noted for any of the observation logs noted in the program logbook, as required.

<table>
<tr><th colspan="4">CINS/FINS QUALITY IMPROVEMENT TOOL</th></tr>
<tr><td colspan="2">Quality Improvement Indicators and Results:
Please select the appropriate outcome for each indicator for each item within the indicator.</td><td>Summary/Narrative Findings:
The narrative write-up is a thorough summary of each assigned QI indicator, explaining how finding(s) are determined.</td><td>Deficiencies/Exceptions:
Please add additional detailed explanations for any items that have any deficiencies or exceptions.</td></tr>
<tr><td colspan="4">Standard One – Management Accountability</td></tr>
<tr><td colspan="3">1.01: Background Screening of Employees, Contractors and Volunteers</td><td>Limited</td></tr>
<tr><td colspan="2" rowspan="3">Provider has a written policy and procedure that meets the requirement for Indicator 1.01</td><td>NO</td><td rowspan="3"></td></tr>
<tr><td>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.</td></tr>
<tr><td>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.</td></tr>
<tr><td>All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.</td><td>Exception</td><td>The agency uses the Predictive Index (PI) pre-employment assessment that was implemented September 2023. A total of 11 staff were hired during the annual review. One of the new staff is a licensed mental health counselor and is exempt from completing the assessment. The tool was administered prior to offer of employment for seven of the 10 applicable direct care staff.</td><td>The agency made an offer of employment to three staff prior to their completion of the pre-employment suitability assessments. One of the three staff did not pass the assessment on the first attempt and received a low score of 2.</td></tr>
<tr><td>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.</td><td>Exception</td><td>Nine of the 10 staff obtained passing scores (six and greater) on a scale of 1-10.</td><td>There's no evidence of one staff re-taking the assessment after receiving a non-passing score.</td></tr>
<tr><td>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.</td><td>No eligible items for review</td><td>None of the new hires had a break in service for more than 18 months.</td><td></td></tr>
</table>

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.)*	Exception	Background screenings for nine of the 11 new hires were completed prior to hire/start dates with eligibility documented on the DJJ background screening results. There were no exemptions required. The program has not utilized any new interns/volunteers during the review period	Two of 11 new staff were hired 2-3 weeks prior to the program receiving an eligibility screening from DJJ Background Screening Unit (BSU).
Five-year re-screening is completed every 5 years from the date of the last screening for all applicable employees and volunteers.	Compliance	The program had three eligible 5-year re-screened staff during the review period. A re-screening was completed timely and reflected active retained prints with the clearinghouse for all three staff.	
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 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 11 new hires.	
Additional Comments: There are no additional comments for this indicator.			
1.02: Provision of an Abuse Free Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		YES If NO, explain here: The agency has the required policy and procedure 1.02, titled Provision of an Abuse Free Environment and 1.02.01 Grievance Process, approved on May 1, 2023 by the Program Director.	
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	Compliance	The program's required code of conduct is included in the Employee Handbook, which is signed by staff, and a copy is placed in each employee's personnel file.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	Compliance	The program documents reports of abuse, grievances, and other incidents in the electronic logbook, as well as the physical Incident Logbook. Interviews with youth and shelter managers were conducted, as well as a review of surveys and the grievance binder. A locked grievance box was observed accessible in the common area, which is checked by the shelter manager. The Quality Assurance (QA) manager also reported checking the grievance box routinely, which were also documented in both the electronic log and the grievance logbooks.	

Youth were informed of the Abuse and Contact Number	Compliance	Throughout the tour of the facility, the Florida Abuse Hotline telephone number is displayed in the common area, the girl's dormitory, and the community counseling unit/counseling offices. It is also included in the client handbook which is reviewed with youth during orientation. All six surveyed youth acknowledged their understanding and access to the hotline number with no staff preventing or restricting them from making a call to the hotline; however, one survey youth indicated they did not know where to locate the number.	
Grievance			
The program(s) have an accessible and responsive grievance process for youth to provide feedback and address complaints. Program director/ supervisor has access to and can manage grievances unless it is towards themselves.	Compliance	The program has a formal grievance procedure which is reviewed with youth during intake. The shelter manager and QA manager have the keys to the grievance box. The grievance box was observed to be mounted on a wall at the entry to the girl's dormitory, including submission forms. All submissions are included in the grievance logbook, and reviewed and signed within the required policy timeframe. Nineteen grievance samples were reviewed.	
Shelter only: Grievances are maintained on file at minimum for 1 year.	Compliance	All reported grievances are maintained within a grievance logbook for at least a year, as required in the program's policy.	
Shelter only: 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 grievance box was observed to be mounted on a wall at the entry to the girl's dormitory, including submission forms. The box was confirmed to be locked.	
Shelter only: There is evidence that grievance boxes are checked by management or a designated supervisor at least daily (excluding weekends and holidays) and documented in the program logbook.	Compliance	Six random weeks during the review period, May– October, were reviewed. The shelter manager and QA manager have the keys to the grievance box, which is checked at least daily, as documented in the Grievance Logbook and the program's electronic logbook.	
Shelter only: Grievances are resolved within 72 hours of being submitted or there was documentation explaining the cause for the delay in providing a resolution.	Exception	All submissions are included in the grievance logbook, and reviewed and signed within the required policy timeframe. Sixteen of the 19 grievances reviewed were resolved within 72 hours.	Of the 19 grievance samples reviewed, three did not indicate client was satisfied and/or resolved matter and did not include evident documentation of Level 2 or 3 resolution, as outlined in the program's policy.

1.03: Incident Reporting			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		YES If NO, explain here: The agency has the required policy and procedure titled 1.03 Incident Reporting (Risk Management), that was approved on May 1, 2023 by the Program Director.	
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	Compliance	Of the 18 CCC reports reviewed. All 18 CCC incidents were reported within the two hours required.	
The program completes follow-up communication tasks/special instructions as required by the CCC	Compliance	All of the 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.	Exception	During the QI Review, one incident was not observed to be reported to CCC.	During the facility tour, it was observed there was no air conditioning in the dormitory due to an outage on 10/10/2024 and staff was still waiting on repair approval. CCC was not notified of the non-working air conditioning system prior to the review and was advised to report the incident. The report was not accepted by CCC.
Incidents are documented in the program logs and on incident reporting forms	Exception	During the QI Review, one incident was not observed to be documented on incident reporting forms.	An incident on 7/8/24 for camera system issue was reviewed. Staff left a message for CCC; however, the incident was not included in the Incident Logbook, but there is an entry within the electronic logbook.
All incident reports are reviewed and signed by program supervisors/ directors	Compliance	CCC reports included in the Incident Reports and electronic logs are reviewed and signed by the shelter manager or authorized program leader/designee.	

1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		NO If NO, explain here: The annual policy and procedure review and approval is overdue, as the last approval was dated 05/01/2023.The program's training policy is missing Narcan/Overdose Prevention, Annual Medication Management for Shelter staff, In-Person CPR training by a certified trainer, Video Camera & Surveillance, Client Intake/Orientation/Screening, Facility Layout, Fire Equipment, and CINS/FINS Petition. The agency has a policy and procedure titled 1.04 Training Requirements, that was approved on 5/1/2023 by the Program Director.	
First Year Direct Care Staff			
All direct care staff have completed a new hire pre-service training provider orientation before they work independently. At a minimum, the orientation included the following: • Agency policies and procedures • Behavior Management (Shelter Only) • Building/Facility layout • File Documentation/development of paperwork requirements and confidentiality • CCC & Incident Reporting • Child Abuse Reporting • Client Intake & Screening • Client Orientation (direct care staff training on delivering new client orientation) • Fire Equipment Safety • Medical and Mental Health Alert System (Shelter) • Risk Management--Including but not limited to the following: - Disaster Preparedness and Emergency Response - First Aid/CPR - Universal Precautions • Video Camera Surveillance & Equipment • All other necessary information to orient a new hire to perform their job role and duties.	Compliance	All four new hire training files reviewed demonstrated staff received pre-service orientation training that included all of the required topics.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	Compliance	All four new hire training files reviewed demonstrated staff completed the required Civil Rights training within the 30 day timeframe.	

All direct care CINS/FINS staff for shelter and community counseling services, including independent contractors (full-time, part-time, and on-call) and interns met the minimum requirement of 80 hours of training for the first full year of employment.	Compliance	All four new hire training files reviewed verified each staff completed a minimum of 80 hours or more of training.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	Exception	Three of the four new hire training files reviewed included documentation of completion of all required trainings within 90-days of hire.	One of the four new hire staff did not complete ACE training during the 90-day timeframe required. The training was completed 19 days late and no explanation was included in file.
Non Licensed Staff Assisting with Medication Distribution			
Any staff without a medical license that assists with Medication Distribution received in-person training from a Registered Nurse prior to administering medication to a shelter youth.	Compliance	All authorized staff training files reviewed included documentation of completion of the required medication management training.	
Staff that are Utilizing NETMIS			
Any staff that is utilizing NETMIS has evidence of completing NetMIS Training in their training file.	Not Applicable	None of the new hires are NetMIS users.	
Staff Participating in Case Staffing & CINS Petitions (within the first year of employment BUT no later 7/1/24 for previous staff)			
Documentation of instructor-led FL Statute 984 CINS Petition Training by a local DJJ Attorney within 1 year of employment or no later than 7/1/24 if hired before 7/1/23. (*Policy went into effect 7/1/23).*	No eligible items for review	One applicable staff hired April 2024 is within the first year of employment and has time to complete the training.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	No eligible items for review	There were no applicable non-licensed clinical shelter staff during the annual review period.	

In-Service Direct Care Staff			
In-service staff completes all of the required annual or 2-year mandatory refresher Florida Network, SkillPro, or other job-related trainings within the required timeframe.	Compliance	A review of four in-service training records found that all four staff members had completed all of the required Florida Network, SkillPro, and job-related training hours.	
Community Counseling Direct Care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.	Compliance	One community counseling staff completed 31 hours of training, exceeding the 24 hours required.	
Shelter Program Direct Care staff completes 40 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(E.g. the program has a DCF child caring license).*	Compliance	All three shelter staff training files reviewed included documentation of completion of more than 40 annual training hours each.	
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 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. Seven of the eight files contained all required documentation. One staff did not have a Skill Pro account and was missing the SkillPro transcript; however, the staff had documentation of completion of the training on DJJ's back-up training website.	
All Staff have completed the Naloxone Training as required within 90 days of hire or 1 year from the policy effective date 7/1/24:	Compliance	All eight training records reviewed supported staff completed the required Naloxone training.	
Additional Comments: There are no additional comments for this indicator.			

1.05 - Analyzing and Reporting Information			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		YES If NO, explain here: The agency has the required policy and procedure titled 1.05 Analyzing and Reporting Information, that was approved on 5/1/2023 by the Program Director. The agency also has a Quality Improvement Plan for FY2024-2025.	
Case record review reports demonstrate reviews are conducted quarterly, at a minimum. *(A summary report of case record reviews, identifying compliance with the CINS/FINS requirements, which is reviewed by management and communicated with staff on a quarterly basis at minimum.)*	Compliance	Case record reviews are conducted by both the QMS and the clinical program staff. Each record review is documented on the File Review Tool that is comprised of 67 questions. The last two case record reviews were conducted for the reporting period January-July 2024 and October 2024, for a total of 26 youth records. Findings are reported for each review and documents the overall percent achieved for all areas reviewed such as requirements for COA, 65-C, Florida Network, individual program requirements, and Journey to Success behavior management system. Case reviews are also reported on the CQI Monthly Spreadsheet Companion Report that is reviewed at the monthly CQI meetings.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	Compliance	The agency has a committee that meets monthly to discuss infection control, safety, and risk management. Monthly meetings were observed to be held May-October 2024 with the exception of August. Incidents and accidents are entered in real time into the agency's Converge Point electronic platform. All staff has access to enter incidents in lieu of using a report form. The system tracks the types of incidents, status of reviews, and generates reports. 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 sent to the leadership staff and emailed to QMS and program supervisors to share with staff. The QMS reviews the reports with staff at monthly staff meetings. Corrective actions are implemented and monitored for any item(s) that below the expected performance rate.	

The program has a process in place to review and improve accuracy of data entry & collection	Compliance	The agency has a data entry team that communicates with program managers to reconcile corrections needed through communications from the Florida Network and ensure data entry is accurate and up-to-date.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	Compliance	All data collected is reviewed monthly and communicated to the local management team at the monthly CQI meetings. The agency has a robust online system for collecting and analyzing data that is displayed on the agency's CQI Analytics and Dashboard. The dashboard is accessible to the QM team and findings are regularly reviewed with staff and stakeholders.	
There is evidence the program demonstrates that 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.	
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 of 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		YES If NO, explain here: 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.	
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 18 authorized drivers and per the program director, all staff are approved by administration. The reviewer viewed supporting documents showing all approved drivers' licenses are valid.	

Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	Compliance	Florida Department of Highway Safety and Motor Vehicles driver's license checks were provided for all 18 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	A total of 10 randomly selected single transports completed during the period were reviewed. Single transports are documented in the program's electronic logbook. Staff's notes of supervisor's approval often do not properly state that approval was given by supervisor. Instead, the note just lists the supervisor's name.	One of 10 single transports did not document supervisor's approval.
When transporting a single client in a vehicle, there was documentation of the following: a. the transporting employee completed check-in by phone at agreed-upon intervals with the senior program leader, or designee, upon departure and arrival. b. the employee check-ins were documented by the manager or designee receiving the call.	Exception	The program does not currently have a protocol in place for staff to check in with management or a designee when transporting a single client. This was also not evident in any of the 10 single transports reviewed.	None of the 10 single transports reviewed documented evidence of check-ins by phone with the senior program leader or designee upon departure and arrival. This was not a practice overall for any single transports.

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	Transportation entries noted in the logbook did not consistently document all of the information required.	Seven of ten single transports did not clearly indicate purpose, and two were missing trip mileage. Two of the transports did not identify the vehicle used.
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.	
The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	Compliance	The community counseling counselor is the designated lead staff to attend the local DJJ council advisory board (CAB) meetings held via ZOOM. Staff provided email/registration documentation to support attendance to all of the CAB meetings held.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	Compliance	The program provided a list of over 40 entities with whom it has previously established an interagency agreement. The list includes providers for educational, legal, homeless, recreational, medical, mental health, LGBTQ, employment, behavioral health, and religious services. These agreements enables the provider to offer additional services to youth and family through referral.	
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	Documentation is verified in NETMIS that events are properly notated and outreach activities/events are conducted by multiple staff members. The NetMIS outreach log includes all required information.	
The program has designated staff that conducts outreach which is defined in their job description.	Compliance	An interview was conducted with the activities coordinator and community counseling counselor. Staff who conduct outreach are also listed on the outreach log and includes program manager, counselors, intake coordinator, and youth care staff.	
Additional Comments: There are no additional comments for this indicator.			

2.01 - Screening and Intake			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		YES If NO, explain here: The agency has the required policy and procedure titled 2.01 Screening and Intake Assessment, that was approved on 5/1/2023 by the Program Director.	
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	Compliance	A total of five residential youth records were reviewed, two open and three closed. All five residential records 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	A total of five community counseling youth records were reviewed, two open and three closed. 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 five residential and five community counseling records reviewed demonstrated evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	Compliance	All ten records reviewed demonstrated youth and parents/guardians receive the available service options and rights and responsibilities of youth and parents/guardians in writing during intake.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	Compliance	All ten youth records 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 records reviewed demonstrated during intake, all youth were screened for suicidality and six applicable youth were assessed further due to being identified as a suicide risk on the screening.	
Additional Comments: There are no additional comments for this indicator.			

2.02 - Needs Assessment			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		YES If NO, explain here: The agency has the required policy and procedure titled 2.02 Needs Assessment, that was approved on 5/1/2023 by the Program Director.	
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 records 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.	Compliance	Nine of the ten youth records reviewed included a supervisor's signature on the completed NIRVANA assessments. One closed residential youth record was signed twice by the same individual in two different roles who was both the assigned counselor and licensed supervisor.	.
(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 records 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	Three applicable closed community counseling and one closed residential record reviewed demonstrated a NIRVANA Post-Assessment was completed at discharge.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	Compliance	One applicable closed community counseling file had a NIRVANA re-assessment completed during the 90 day requirement.	
All files include the interview guide and/or printed NIRVANA.	Compliance	All ten records reviewed included the NIRVANA interview guide and/or a printed NIRVANA.	
Additional Comments: There are no additional comments for this indicator.			

2.03 - Case/Service Plan			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		YES If NO, explain here: The agency has the required policy and procedure titled 2.03 Case Service Plan Development, that was approved on 5/1/2023 by the Program Director.	
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 youth records 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	Eight of the ten youth records reviewed demonstrated case/service plan is developed within seven working days of NIRVANA. One residential youth was discharged on 7th day and did not have a case plan. Additionally, one community counseling record indicated the youth and parent refused services.	
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	Two of the eight applicable case plans reviewed were found to be fully compliant with the requirement of the indicator. One or more element was missing from the remaining six records reviewed.	Two closed residential records were missing target dates, four were missing the youth's signature and three were missing the signature of the parent/guardian. Two closed community counseling records were missing the location of services, one closed record was missing the parent signature, and one closed record was missing the actual completion date.
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	Four applicable Case/ Service plans were reviewed for progress and revised by counselor and parent every 30 days for the first three months.	
Additional Comments: There are no additional comments for this indicator.			
2.04 - Case Management and Service Delivery			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		YES If NO, explain here: The agency has the required policy and procedure titled 2.04.01 Service Follow-up and Aftercare, that was approved on 5/1/2023 by the Program Director.	
Counselor/Case Manager is assigned	Compliance	Each of the ten records reviewed 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 applicable records reviewed demonstrated referral needs were identified and coordination of referrals to services based upon the on-going assessment of the youth's/family's problems and needs. It was also evident the case worker coordinated service plan implementation, monitored youth's/family's progress in services, provided support for families, referred the youth/family for additional services when appropriate, and provided case monitoring in all ten records. One of the ten records reviewed was applicable for monitoring of progress for court ordered youth in shelter. None of the records were applicable to making referrals to the case staffing to address problems and needs of the youth/family, and accompany youth and parent/guardian to court hearings and related appointments as none were reported during the review period. All six closed records included termination notes. Thirty and 60 day follow ups were completed timely in six applicable files.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	Compliance	The program maintains written agreements with diverse community partners that include services provided and a comprehensive referral process.	
Additional Comments: There are no additional comments for this indicator.			
2.05 - Counseling Services			**Satisfactory 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 titled 2.05 Counseling Services and Family Involvement, that was approved on 5/1/2023 by the Program Director.	
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	Group sessions were reviewed for random 2-week periods each month and were observed to be completed for the following dates: February: 02/03/24 - 02/09/24 and 02/11/24 - 02/17/24 March: 03/03/24 - 03/09/24 and 03/17/24 - 03/23/24 June: 06/03/24 - 06/09/24 and 06/09/24-06/15/24 July: 06/30/24 - 07/06/24 & 07/07/24- 07/13/24 August: 08/04/24-08/10/24 & 08/11/24 - 08/17/24 September: 09/01/24 - 09/07/24 & 09/08/24 - 09/14/24	Groups were not held during the following periods listed: April 04/02/24 - 04/09/24 and 04/21/24 - 04/27/24 (Missing 2 groups); May 04/28/24 - 05/04/24, (Missing 2 Groups); 05/05/24 - 05/11/24 (Missing 1 Group); October 10/06/24 - 10/12/24 (Missing 1 group); and 10/13/24 - 10/19/24 (Missing 1 Group).
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 binder. Group logs reviewed supported all groups were held for at least 30 minutes with a designated facilitator, include a relevant topic, and opportunity for youth participation.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	Compliance	All groups reviewed have correct documented information such as staffing, sign in sheet, length of time, and topic.	
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 files reviewed are labeled confidential and maintained in Lauris Online, an electronic database. Access to the online system was provided to the team and intake documentation was printed to facilitate the review.	
Case notes maintained for all counseling services provided and documents youth's progress.	Compliance	Case notes were maintained in all of the files indicating the youth's progress as well as case notes for all services provided.	
On-going internal process that ensures clinical reviews of case records and staff performance.	Compliance	All cases reviewed undergo a process that ensures clinical reviews of case records and staff performance. In addition peer record reviews are conducted monthly for a sample of case records and deficiencies are identified and addressed by management.	
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 files reviewed had virtual intakes.	
Additional Comments: There are no additional comments for this indicator.			
2.06 - Adjudication/Petition Process			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06		YES If NO, explain here: The agency has the required policy and procedure titled 2.06 CINS Adjudication and Petition Process, that was approved on 5/1/2023 by the Program Director.	
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	Compliance	Case staffing documentation demonstrated the program has a case staffing committee that includes a DJJ representative, CINS/FINS 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	Compliance	Per the program's policy and procedure, other members of the committee may include: State Attorney's Office; others requested by youth/ family; substance abuse representative; law enforcement representative; DCF representative; and mental health representative.	
The program has an established case staffing committee, and has regular communication with committee members	Compliance	The agency has established a case staffing committee in the event the youth/family is not in agreement with services or treatment; the youth/family will not participate in the services selected; or the program receives a written request from a parent/guardian or any other member of the committee.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	Compliance	The case staffing meetings will be held if requested, including emergency case staffing. Members of the committee are notified via email when a case staffing is scheduled to be convened.	
The youth and family are provided a new or revised plan for services	Compliance	One case staffing held during the review period was reviewed. The youth and family were provided a copy of the revised service plan, based on the committee's recommendations, at the conclusion of the case staffing.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	Compliance	The program documents the committee's recommendations and provide a copy to the youth and family at the conclusion of the case staffing meeting.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	Compliance	The youth was arraigned 9/10/24 and the program maintains documentation to show communication with the circuit court for the judicial intervention.	
Case Manager/Counselor completes a review summary prior to the court hearing	Compliance	One applicable review summary was documented in the youth's record prior to the court hearing. The first Review Summary was completed 10/8/24 and hearing was held 10/15/24.	
Additional Comments: There are no additional comments for this indicator.			

2.07 - Youth Records			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		YES If NO, explain here: The agency has the required policy and procedure titled 2.07 Youth Manual and Electronic Medical Records, that was approved on 5/1/2023 by the Program Director.	
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. If information is printed they are labeled confidential	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	Compliance	All files are electronically kept in Laurus system with staff login. Any printed 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	Compliance	The Lauris Online electronic records are organized in a consistent manner to maintain chronology and order for the various sections of the youth record.	
SHELTER FILES contain the following: Table of Contents that outlines documents in each section: •Screening •Informed Consent • Photograph of the youth • Shelter Intake Form • Suicide Assessment (if needed) • NIRVANA Self Report (NSR) • NIRVANA full Assessment • Plan of Service • Chronological Notes • Medication Inventory Form • Approved contact list • Copies of referrals made & Follow-Up (if needed) • Discharge summary once case is closed	Compliance	All shelter records reviewed had an outline that contains all of the information required for each file in chronological order.	

COMMUNITY COUNSELING FILES contain the following: Table of Contents that outlines documents in each section: • Screening • Informed Consent • Community Counseling Intake Form • Suicide Assessment (if needed) • NIRVANA full Assessment • Plan of Service • Chronological case notes • Copies of referrals made & Follow-Up (if needed) • Discharge summary once the case is closed	Compliance	All community counseling records reviewed had an outline that contains all of the information required for each file in chronological order.	
All records kept electronically, are maintained securely and can be made immediately available upon request for audit purposes.	Compliance	The records are electronic and are password protected and encrypted for confidentiality. Lauris prompts the staff to change password frequently in order to access and use the system.	
Records are retained for the duration of the time specified by the contract.	Compliance	Per the agency's policy and procedure, records are retained for the required duration of the contract.	
Additional Comments: There are no additional comments for this indicator.			
2.08 - Specialized Additional Program Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		YES If NO, explain here: The agency has the required policy and procedure titled 3.07 Special Populations, that was approved on 5/1/2023 by the Program Director.	
Staff Secure			
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)			
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 DMST during the annual 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			
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 residential DV youth records were reviewed, two closed and one open.	
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.	No eligible items for review	None of the three youth had a DV Respite length of stay exceeding 21 days.	
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	Compliance	The case plans for the three youth reflected goals for anger management and family coping skills.	
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			
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	One probation respite youth was served during the annual review.	
All probation respite referrals are submitted to the Florida Network.	Compliance	Documentation supported the referral was submitted to the Florida Network for approval.	
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	Compliance	The youth record included a copy of the DJJ face sheet submitted with evidence of referral from DJJ Probation and probation status with pending charges.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	Compliance	A review of NetMIS verified data entry was completed within three business days of intake and discharge	
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	Length of stay for the youth was 10 days, which did not exceed the 14-30 day timeframe required.	

All case management and counseling needs have been considered and addressed	Compliance	The case plan for the youth reflected goals for addressing youth's behavior and counseling services needed.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	Compliance	Youth record demonstrated the youth participated in services consistent with other general CINS/FINS population while in care.	
Intensive Case Management (ICM)			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	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)			
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.	
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services with the required documents: a. Florida Network Youth Screening Form b. SNAP® Brief Intake Screening Checklist	Not Applicable	LSF Miami Bridge is not contracted to provide SNAP services.	
All files contain each of the required documents below: a. SNAP Child Screening Interview Report b. Florida Network Community Counseling Intake Form c. Reinforcement Trap/Coercive Cycle Diagram d. Consent to Treatment and Participation in Research Form	Not Applicable		
The NIRVANA was completed at initial intake, or within two sessions.	Not Applicable		
There is evidence of the completed the Pre - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	Not Applicable		
There is evidence of the completed Pre - TOPSE is completed by the caregiver and is located within the file.	Not Applicable		

There is evidence of the following documents located within the file: a. SNAP® Parent Goal Sheet b. Child Way To Go Goal Sheet (*This may be in progress for open files but is required for all closed files.*)	Not Applicable		
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed the Post - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	Not Applicable		
There is evidence of the completed Post - TOPSE is completed by the caregiver and is located within the file.	Not Applicable		
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	Not Applicable		
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	Not Applicable		
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	Not Applicable		
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services using the Florida Network Youth Screening Form.	Not Applicable		
The file contains the completed Florida Network Community Counseling Intake Form and is located within the file.	Not Applicable		
The Consent to Treatment and Participation in Research Form is completed, signed by the parent/guardian before receiving services, 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		
All closed files contained evidence in the file a NIRVANA was completed at discharge.	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 'Way to Go Goal' Sheet within the file.	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 SNAP® for Schools & Communities Feedback Form completed by the supervisory adult responsible for the support of the youth receiving services and entered into NetMIS.	Not Applicable		

<table>
<tr><td>There is evidence of one (1) Fidelity Adherence Checklist completed per classroom for the 13-week classroom sessions which is located in the file.</td><td>Not Applicable</td><td></td><td></td></tr>
<tr><td colspan="4">Additional Comments: There are no additional comments for this indicator.</td></tr>
<tr><td colspan="3">3.01 - Shelter Environment</td><td>Satisfactory with Exception</td></tr>
<tr><td colspan="2" rowspan="3">Provider has a written policy and procedure that meets the requirement for Indicator 3.01</td><td>YES</td><td rowspan="3"></td></tr>
<tr><td>If NO, explain here:</td></tr>
<tr><td>The provider has the required policy and procedure titled 3.01 Shelter Care that was approved 5/1/2023 by the Program Director.</td></tr>
<tr><td>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.</td><td>Exception</td><td>During the onsite review, the facility was undergoing construction and one of the dormitory was closed off. A tour of the shelter revealed that all the furnishings in the common area are in fair condition. There are scratches and some coloring on the wood portion of the chairs, and a few of the cushions have tears in them. There are two lockers in the girl's dorm that have doors that are not tightly/properly fitting the frame. There was no evidence of insect infestation. Due to the construction of the facility, the bathroom in the girl's dorm was the only one accessible. The bathroom has three showers and three bathroom stalls. One of the stalls is handicap accessible, and has its own sink inside of the stall. The showers, sinks, and toilets are functional and there was no evidence of leaks, dust or mildew. The bathroom did not have a foul odor. There was no evidence of any graffiti on the walls, doors, or windows in the areas that were accessible, which included the common areas/dayroom, reception area, kitchen, girl's dorm and bathroom, and the hallways throughout the facility. Every available area throughout the facility has proper lighting for tasks to be performed. There was no debris found in the exterior areas, during the tour of the grounds. The grounds are free of hazards, with no obstruction or safety issues identified. Garbage cans around the facility were covered, and no waste was found around the dumpster or garbage cans. All interior and exterior doors are secure. The front door entrance and exit doors are secured with keypads which require either a passcode, or key fob. All doors were properly secured. All staff on shift utilized the key fob to enter or exit those doors. Per interview with staff, as an added security measure, only management has the actual code. The key control which is kept in the staff's office behind a locked door is in compliance. The staff signs keys out at the beginning of their shift, and signs the keys back in at the end of their shift, and this process is noted in Note-Active. There are detailed egress maps located in the dayroom, staff's office, the girl's dorm, and hallway near the boy's dorms, and the general client rules are located in the dayroom as well as the hallway by the girl's dorm.</td><td>There are loose objects, specifically several fans, observed in the girl's dorm with attached cords that are being utilized, that could become hazardous or unsafe for the shelter's environment. The Maintenance employee stated that the A/C stopped working October 10th, and that a work-order was submitted.</td></tr>
</table>

Additional Facility Inspection Narrative (if applicable)	The abuse hotline number and incident reporting information is posted in the staff's office and the girl's dorm; again these sightings are based on the accessible areas from the construction that is in process. There is a locked grievance box, and grievance forms located on the wall in the dayroom. The interior areas did not contain any contraband.		
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.	Exception	The facility has two vans used for transportation, a white 2011 Ford E-50 bus, and a blue 2015 Chevrolet Express van, each is up-to-date with inspection and insurance, and fully equipped with one-Flashlight, one-glass breaker, and one seat belt cutter. The blue van's fire extinguisher was last inspected May 2024, and the white van's fire extinguisher was last inspected December 2023. During the inspection of vehicles, all agency and staff vehicles were locked.	The white van had an expired bottle of wound wash, in which the staff member removed from the van, and stated it would replace it with a non-expired bottle.
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 behind a locked door in the front of the laundry room. A review of the chemical inventory log shows the overnight staff completing the inventory of the approved chemicals. The MSDS Log is kept in the laundry room by the stored chemicals. The book included all MSDS forms for the listed chemicals. A review of the facility's chemical inventory log showed that the chemicals are perpetually accounted for, and there was proof of weekly inventories. There were a few staff initials missing for the counts; however, it was not a widespread deficiency.	

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	There are two washers, and two dryers located behind a locked door in the laundry Room, are all operational, and the dryer's lint collectors were clear of lint. The current DCF Child Care License was posted in the staff's office with an effective date of June 1, 2024. The girl's dorm is the only dorm accessible due to the current construction of the facility. The dorm was furnished with individual beds for the youth, and the mattresses appeared cleaned. Each bed had individual linen, pillows and a blanket. There are storage cabinets in the dorm with locks on each one for the youth to place their personal items in. It was observed two of the cabinets have doors that are not properly closed at the top, and not properly fitting the frame of the cabinet.	
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 most recent fire inspection was conducted on May 29, 2024, no violations were noted at the time of the inspection. All fire drills were completed at least once monthly on the 1st shift and 2nd shift. The 3rd shift conducted fire drills monthly except for one month. All shifts completed one mock emergency drill per the standard. All fire extinguishers are easily accessible. The interior fire extinguishers have different inspection dates. Most have an inspection date of December 2023, but one had an inspection date of May 2024. The fire extinguisher in the blue van has an inspection date of May 2024, and the white van's inspection date is December 2023. The annual fire safety equipment inspections are valid and up to date.	One fire drill on the 1st shift and four fire drills on the 2nd shift were not conducted within the allotted 2 minutes or less during the review period. There was no fire drill conducted on the 3rd shift in the month of August.
Fire and Safety Health Hazards: a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health. b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually. c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored. d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.	Exception	The agency's current satisfactory Residential Group Care inspection report was satisfactorily completed 12/05/2023. The most recent food service inspection report was completed on August 14, 2024. The menu was observed in the kitchen and is signed by a licensed dietician. The storage areas are clean. The refrigerators and freezers were also clean and maintained at the required temperatures. All appliances were operable, clean, and ready for use as needed.	All food was stored properly; however, there are several opened/left-over items that do not have dated labels. There is a posting on the refrigerator which clearly states to label all opened items.

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	Per the documentation, and camera reviews, the youth are engaged in education, recreational, counseling, life and social skill trainings seven days per week during awake hours. There was very minimal downtime identified. The youth went on a "arts" outing while the review was in process. Two staff members were interviewed about the outing and reviewer was informed youth are able to make different forms of art, color, paint and design when they are on this outing. The weekly program schedules as well as observations show that the youth are engaged in at least one-hour of physical activities daily. The weekly program schedule includes an outing to Friendship Holiness Church, Branches Worship Service on Sunday mornings 10:30am or 10:45-1:00pm. Church outings are documented in the Note-Active as "Spiritual Outings." The note-active also shows various activities and/or outings that youth participate in if they do not attend the faith-based outings. The daily program schedule reflects days and times allotted for homework and quiet times. The program's living room has book cases with a variety of age appropriate books that are available for the youth, and the seating is arranged that the youth can have a quiet space to read. The daily programming schedule is posted throughout the common areas in the facility including the staff's office and on the wall in the common area.	
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.	
Youth received a comprehensive orientation and handbook provided within 24 hours	Compliance	All five youth records reviewed have an orientation checklist indicating the youth received a comprehensive orientation within 24 hours.	

Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	Compliance	All files have a checklist with the staff and youth's signature indicating topics covered during orientation explained the program's disciplinary action, program rules, grievance procedure and emergency procedures, the contraband policy, tour, how to contact the abuse hotline. Suicide prevention and room assignment are reviewed during intake but are not listed on the checklist.	
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	A copy of the orientation checklist was present in each of the five files reviewed and were signed by the youth, parent/guardian, and staff conducting orientation.	
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.	
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 five records reviewed 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. The records also include documentation of the youth's sexual behavior, sexual orientation, suicide risk and if isolation is necessary.	
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	Compliance	All files show documentation of noted alerts, collateral contacts and the youth's initial interactions and observations. An alert system is immediately initiated for youth identified with alerts.	
Additional Comments: There are no additional comments for this indicator.			

3.04 - Log Books			Satisfactory with Exception
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.	
Log book entries that could impact the security and safety of the youth and/or program are highlighted	Compliance	A random sample of two week periods for each of the past six months was reviewed for this indicator. The periods reviewed were: 05/01/2024-05/15/2024; 06/06/2024-06/20/2024; 07/01/2024-0715/2024; 08/06/2024-08/20/2024; 09/01/2024-09/15/2024; and 10/10/2024-10/24/2024. The agency uses a highlight system for the e-logbook which is consistent and easy to follow. The highlight system helps to distinguish and track significant activity. The occurrence of fire drills, youth movement and critical incidents was highlighted as well as activities which could impact the security and safety of the youth or the program. Examples of highlighted information include contraband searches, runaway, and sight and sound occurrences, baker act, youth refusing to go to bed, youth bullying another youth, youth illness/injury, and physical altercation	
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	The facility utilizes an electronic log, Note-Active, for documentation. All log entries reviewed met the required documentation of date, time, incident/activity/event, and the youth and staff names that were involved. Statements were concise, providing the pertinent information, and the name and signature of the person making the entry was electronically signed in Note-Active.	
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	All errors recorded in Note-Active had straight-lined strike-throughs which included the staff's name, the date and the time documented.	
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	Evidence of documentation from the program director shows that the logbook is reviewed weekly. During the dates reviewed, any corrections or follow-ups needed were noted, and Note-Active electronically adds the date, time and the signature of the Program Director.	
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	Documentation reveals that the scheduled direct care staff reviews the logbook for at least the two previous shifts at the beginning of their shifts. The Note-active electronically adds the date, time and signature of the staff who added the note.	

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.	Exception	Per the requirement, Supervisor notations in Note-Active includes all pertinent information, since their prior log entry. The Supervisors highlight their documented notations.	There were two Counselors recently hired per the staff roster, one on 07/15/2024, and one on 09/03/2024. A review of the Note-Active for those dates, revealed that the counselors did not log any reviews of the log, as there are no notes from the counselors since their hire date.
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	Compliance	Staff's documentation of resident counts and supervision of the residents was evident in the Note-Active. Visitation and home visits are documented with the youth's name included. Note-Active electronically adds the time of the visitation, and the home visit outings.	
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.	
The program has a detailed written description of the BMS and it is explained during program orientation	Compliance	Program uses Journey to Success incentivized BMS behavior system that has rewards weekly.	
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. Youth have listed incidents that will cause them to no longer earn points. Youth can always earn points on the upcoming shift if they lose their points for a major infraction.	
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 and training files for four new hires support this practice.	
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. Youth are allowed access to grievance forms which they submit in the grievance box and supervisor will review the grievance.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	Compliance	All staff including supervisors receive training on BMS when hired.	
Additional Comments: There are no additional comments for this indicator.			
3.06 - Staffing and Youth Supervision			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		YES If NO, explain here: The program has the required policy and procedure, 3.06, Staffing and Youth and Staff Supervision, that was last approved and signed by the Program Director on May 1, 2023.	

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	An interview with two staff members and the shelter's manager, verified how the scheduling ensures that the staff to youth ratio stays in compliance. Weekly staff schedules, the cameras, and the Note-Active, each showed that at least a minimum of two staff were scheduled and worked each shift to comply with the contract.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	Compliance	A review of the staff schedules including one that was posted in the staff's office, showed the rotation of at least two staff per shift. All program staff had successfully completed all necessary trainings, and background screenings prior to working with the youth. The schedule shows that a minimum of two staff per shift are scheduled, and during camera reviews, two or more staff were present on each shift.	
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. Training records for four new staff show staff receive pre-service training prior to working independently with youth.	
The staff schedule is provided to staff or posted in a place visible to staff	Compliance	Staff's schedule is visibly posted in the staff's intake office near the staff's desk.	
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	The holdover overtime roster with phone numbers included is located in the staff's office by the schedule, as well as, a volunteer list of staff that are willing to work in case of a disaster.	

Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	Exception	Bed Check Dates/Times randomly selected and reviewed are: • September 27th, 12am-2am • October 2nd, 2am-4am • October 6th, 4am-6am • October 12th, 1am-3am • October 14th, 3am-5am A review of the camera with the Program Manager was conducted for the above mentioned timeframes. Overall, the bed checks were completed accurately and within the 15-minute timeframe; however, there were five bed checks that were not. The physical layout of the Girl's Dorm has the bunk beds nicely separated from each other. As you enter the dorm, straight ahead are the lockers, to the right of the door, one set of bunk beds is near the door, and one set of bunk beds are in the far right corner, the space between the two bunk beds, had floor fans and a love seat. The left side of the dorm has one set of bunk beds near the door with a space before the next set of bunk beds, and the final set is in the far left corner. The room is very spacious.	Bed check dates/times reviewed that were not completed within the 15 minutes requirement were observed to be to be as follows: • September 27th, 12am-2am, bed check was missed between 12:15-12:36am • October 2nd, 2am-4am, bed check was missed between 2:15-2:32am • October 12th, 1am-3am, bed check was after 1:00am was late at 1:17am, late at 1:34am, and late 3:03am, after the 2:45am bed check.
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 program has the required policy and procedure, 3.07, Special Populations, that was last approved and signed by the Program Director on May 1, 2023.	
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	There is a notice posted at the front of the facility which states that the facility is being monitored 24-hours a day. During the camera reviews with the Shelter Manager, it was observed the program was able to view images that had been captured and retained 30 days and longer. The recordings had great resolution from the images that were retained during the camera reviews. The system recorded the date, time and location of retained images. The facility has 32 cameras, 16 interior and 16 exterior. They are placed in the day room, hallways near the male and female's dorm, hallway near the laundry room, dining area, entryway, lobby, recreation area, patio, parking lot and other pertinent areas around the facility. There were no cameras placed in bathrooms or the sleeping areas/dorms. All the cameras were operable, and displayed a clear view, with the exception of the one located near the girl's dorm hallway in which there is an obstruction which blocks a full view of the person completing the bed checks. Per the Shelter Manager, there is no generator available for the video surveillance system, however, the Director confirmed there is backup power in case of 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 list of designated personnel who can access the video surveillance system is posted in the staff's office. The Shelter Manager and the QI Manager are the only two staff that have off-site capabilities.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	Exception	Supervisory video reviews are conducted by the shelter manager and documented to assess the activities of the facility. May reviews were conducted May 14th 22nd, and 31st. June's reviews were conducted June 5th, 6th, 12th, 19th, and 22nd. July's reviews were conducted July 2nd, 13th, 20th, and 27th. August's reviews were conducted August 15th and 22nd. September's reviews were conducted September 10th, 19th, 22nd, 25th, and 30th. October's reviews were conducted October 4th, 11th, and 18th.	There were two gaps observed for supervisory biweekly video reviews. A biweekly review was due by August 10th but not completed until the 15th. Similarly, a biweekly review was due by September 5th but not completed until the10th.
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	Compliance	The reviews did show that assessments of the activities of the facility were viewed, and the timeframes did include random samples of the overnight shift.	
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 Shelter Manager processes any requested reviews from third parties within the timeframe allotted. Examples were provided for when law enforcement had requested the video, and it was processed.	
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	Exception	An issue occurred where the CCC was called on 07/08/2024 at 1:47am with regards to camera system failure. All cameras were observed to be operable at the time of the onsite visit.	There was no follow-up noted or any documented evidence presented during the review to show service order/request was made within 24 hours and all efforts had been made to obtain repairs promptly.

Additional Comments: There are no additional comments for this indicator.

4.01 - Healthcare Admission Screening			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.01		YES If NO, explain here: The agency has the required policy and procedures titled 4.01 Healthcare Admission Screening (Physical Health Screening) that was approved December 7, 2023 by the Program Director.	
Preliminary Healthcare Screening			
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	Compliance	A total of five residential youth records were reviewed, two open and two closed. The program's healthcare screening form includes all of the conditions required. Healthcare Admission Screening Forms were completed at the time of intake by direct care staff and reviewed by the nurse within three business days.	
Referral and Follow-Up			
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	Compliance	Two of the five youth had a chronic medical condition that was mentioned during intake. Both youth records contained a referral to ensure medical care. An interview with the program's registered nurse reported that medical follow up referrals are documented in the electronic medical record on the Medical Documentation form, staff communication binder, and client medical file which was also observed.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	Compliance	Two of the records indicated the parent/guardian needed to be involved in healthcare services while the youth were in the program. Documentation in the electronic medical records indicated each youth parent was involved with the co-ordination of service needed.	
All medical referrals are documented on a daily log.	Compliance	Each youth electronic medical record indicated the healthcare referrals are documented on a daily log maintained in the youth electronic medical record.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	Compliance	The program's policy states they will work with the youth's parent/guardian and the provider's medical consultant, if needed, to ensure the youth receives proper medical care and follow-up.	

Additional Comments: There are no additional comments for this indicator.

4.02 - Suicide Prevention			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		YES If NO, explain here: The agency has the required policy and procedures titled 4.02 Suicide Prevention, that was approved May 1, 2023 by the Program Director.	
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	Six youth records were reviewed for five residential and one community counseling youth. Documentation verified all six youth received a suicide risk screening during the initial intake and screening process. Each reviewed suicide screening result was reviewed and signed by a licensed supervisor and was maintained in the youth electronic record.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	Compliance	The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	Compliance	Documentation verified an assessment of suicide risk (ASR) was completed for all five residential youth who were placed on the appropriate level supervision based on the result of the suicide risk assessment.	
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	The staff person(s) assigned to monitor the five youth documented the supervision observations of the youth's at 30 minute or less intervals. The observations were noted in the program's electronic logbook.	
Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log.	Exception	Staff documents observation in the program's electronic logbook; however these entries do not include all the required information.	The logbook observation notes did not contain any supporting evidence regarding the youth's behavior observations or any warning signs as required for the observation.
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	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. Follow up assessments and instructions to remove youth from sight and sound were present in each of the five records reviewed.	
There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.	Exception	The logbook supervision notes are entered by the youth care staff conducting the observation on each shift; however, there were no notes observed indicating documentation was reviewed by supervisory staff each shift.	None of the observation logs noted in the program's electronic logbook included supervisory reviews.
Youth with Suicide Risk *(Community Counseling Only)*			

Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	Compliance	One applicable closed community youth record documented a suicide risk assessment was immediately completed by a non-licensed professional under the direct supervision of a licensed mental health professional during intake. Documentation supported the youth parents and supervisor were notified of the youth results.	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	Compliance	Documentation showed the youth Assessment of Suicide Risk was completed by the program licensed professional and parent was notified of the results.	
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 also showed information on resources available in the community for further assessment was provided to the youth parent and was documented in the youth electronic file and signed by the youth parent.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	Not Applicable	Parent was present and informed.	

When the screening was completed during school hours on school property, the appropriate school authorities were notified.	Not Applicable	Screening was completed at the youth's home.	
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		NO If NO, explain here: The provider's policy was not updated to include storage of Naloxone so staff can access it in the event of emergency or checking of Naloxone kits each year to ensure they are current and not expired. The agency has a policy and procedures titled 4.03 Medications (Storage, Access, Inventory, Administration, Documentation and Disposal), that was approved May 1, 2023 by the Program Director.	
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 nurse provided documentation to support all non-nursing staff authorized to distribute medication received in person training by the nurse. Documentation included a sign-in sheet and dates of medication training. Training records for the four new staff validated the new staff also received 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	Staff meetings are at least bimonthly and there is a standing medication agenda item for the nurse to discuss medication trends, strategies, and provided necessary training. Staff meetings were held in April, May, July, and September.	
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	Compliance	The nurse stated that a two hour time frame is scheduled for medication distribution to ensure medication is being distributed in a timely matter, one hour before and one hour after the set time of the original time of dosage.	

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 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 as authorized 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 program maintains an alert board that identifies youth receiving medication. In addition, each youth on medication has an accessible medication record that lists the medications, times, and dosage. Staff who have completed the required training and are permitted to assist with medication distribution are also delineated on the staff schedule.	
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 nurse reviews all medical documentation each day to ensure proper medication management and distribution methods. The facility has a delivery process for medications that is consistent with the FNYFS Medication Management and Distribution Policy. There is also an internal quality assurance process in place. The facility identifies medication issues and discusses medication management and errors during CINS/FINS meetings.	
Admission/Intake of Youth			
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	Upon admission, medical information is either documented by a staff member or the registered nurse. Documentation supported the registered nurse reviewed all medical information recorded by staff within three business days if not present during admission. There was documentation to support the shift supervisor also reviewed the documentation the day of admission. Intake documentation is reviewed and signed by the program manager by the next business day.	

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	The program stores all medications in the Pyxis machine that is located inside the medical office. There is a refrigerator with temperature for medication requiring refrigeration in the room as well. Oral medications are stored separately from injectable epi-pen and topical medications. The program does not accept any youth prescribed injectable medication except for epi-pens. Observation supported the Pyxis machine is stored in accordance with guidelines in FS 499.0121 and the program policy section in Medication Management. Also, the Pyxis keys were labeled and are accessible to only staff in the event they need to access medications if there is a Pyxis malfunction.	
Medication Distribution			
a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual e. When nurse is on duty, medication processes are 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	Documentation showed all the program staff are trained on medication management, and have access to secured and all medications. There are a minimum of two system managers for the Pyxis machine. Only designated staff delineated in user permissions have access to controlled substances. A medication distribution log is utilized for all medication distribution by licensed or non-licensed staff. The program verifies medications using one of the three methods listed in the FNYFS Policies and Procedures Manual. When the nursing staff are on duty, medication process are conducted by the nurse. The delivery process of medication is consistent with The Florida Network of Youth and Family Services (FNYFS) medication management and distribution policy. The nursing staff verify medication using the approved methods listed in the FNYFS Operations Manual. The program does not accept youth requiring prescribed injectable medications, except for epi-pens. All non-licensed staff have received training from the program nurses on the use of epi-pens, with refreshers completed each time a new youth is admitted to the program with one.	
The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given c. evidence of staff initials that the dosage was given	Compliance	A total of three applicable youth residential records (two closed and one open) 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	All three youth records indicated medication was provided within one hour of the scheduled time. There was no instance where youth was not provided medication within the required timeframe during the review period.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	Compliance	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.	No eligible items for review	There were no medication errors reported during this review period.	
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	The program provided a report of youth records applicable for controlled substances during the review period. Three youth records were reviewed. Documentation indicated the controlled medication was counted from shift-to-shift by two staff, and there were staff signatures. Non-controlled and over-the-counter medications are inventoried weekly in addition to the documented perpetual count. Documentation reflects sharps and syringes are secured and counted weekly.	

There are monthly reviews of the Pyxis reports to monitor medication management practice.	Compliance	Documentation supported there are monthly reviews by the program nurse of the Pyxis reports to monitor medication management practice.	
Medication discrepancies are cleared after each shift.	Compliance	Documentation supported all medication discrepancies are cleared during each shift. There were no outstanding discrepancies observed during the review.	
Additional Comments: There are no additional comments for this indicator.			
4.04 - Medical/Mental Health Alert Process			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.04		YES If NO, explain here: The agency has the required policy and procedures titled 4.04 Medical and Mental Health Alert Process, that was approved May 1, 2023 by the Program Director.	
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	Compliance	A total of five residential files were reviewed, two open and three closed. Each of the youth records reviewed indicated the youth had medical, mental health condition and/or food allergies. All five youth were placed in the program's alert system which includes precautions concerning prescribed medications, mental health conditions, allergies and medication side effects.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	Compliance	The program's alert system includes precautions concerning the prescribed medications, medical and mental health conditions. Alerts are documented in the medical book and on each youth electronic medical record. An alert board located in the intake office also documents the youth name and alert in a confidential manner. A nutritional alert form will be in the kitchen which includes a list of youth who have an allergy or other kind of nutritional alert. All five youth closed residential records were in compliance. The program currently did not have youth on site during the annual review for observation of the process.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	Compliance	An interview with the program's RN reported all staff are provided sufficient training information and instruction to recognize/respond to the need for emergency medical/mental health problems which was observed in a total of eight staff training files reviewed.	

A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	Compliance	The program's alert system is in place to ensure information concerning youth medical condition and mental health treatment information is communicated to all staff. Each of the five residential youth record demonstrated alerts were documented in the files and communicated to staff.	
Additional Comments: There are no additional comments for this indicator.			
4.05 - Episodic/Emergency Care			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.05		YES If NO, explain here: The agency has the required policy and procedures titled 4.05 Episodic / Emergency Care, that was approved May 1, 2023 by the Program Director.	
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	Compliance	Three youth records were reviewed for emergency and/or episodic care. There was an incident report completed for all three incidents. Upon each youth's return, documentation confirmed the medical clearance was present in the youth's record. In all three incidents, documentation supported the youth's parent/guardian was notified. The episodic log does not differentiate offsite medical transports from onsite emergency care provided.	
All staff are trained on emergency medical procedures	Compliance	A total of eight staff training records were reviewed. Documentation supported all the staff received training on emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	Compliance	In total, the program has 4 knife-for-life and 5 wire cutters that were observed to be in secure locations. Observation showed the knife-for-life and wire cutters are accessible to all staff. Knife-for-life are located in each building and transportation vans; wire cutters are located in the intake office, kitchen, community services building, and one on each van.	
Additional Comments: There are no additional comments for this indicator.			