



**Florida Network for Youth and Family Services  
Compliance Monitoring Report for**

**LUTHERAN SERVICES FLORIDA – MIAMI BRIDGE (HOMESTEAD)**

326 NW 3 Avenue  
Homestead, FL 33030

**March 5-6, 2025**

**Compliance Monitoring Services Provided by**



## EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the Lutheran Services Florida Miami Bridge Homestead (LSF Miami Bridge Homestead) for the FY 2024-2025 at its program office located at 326 NW 3 Avenue, Homestead. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. LSF Miami Bridge Homestead is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance, and are funded with General Revenue Funds effective from July 2024 through June 30, 2025.

The compliance monitoring review was conducted by Marcia Tavares, Consultant for Forefront LLC. Agency representatives from LSF Miami Bridge Homestead present for the entrance interview were: Shelia Dixon, Regional Director; Dr. Toshiba Mitchell, Program Director; C.J. Fernandez, QA Management Specialist; Raquel Lumia, Clinical Director; Tracy Scott, Registered Nurse; Lashonda Chavis, Intake Coordinator; Lashay Richardson, Sr. Administrative Assistant; and Nathalie Alvarez, YCS III. The last onsite QI visit was conducted on April 24, 2024.

In general, the Reviewer found that LSF Miami Bridge Homestead is in compliance with specific contract requirements. LSF Miami Bridge Homestead **received an overall compliance rating of 100% for achieving full compliance with 12 indicators** of the CINS/FINS Monitoring Tool. There were no recommendations or corrective actions 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](mailto:keithcarr@forefrontllc.com)

**2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL**  
**Report Number: CM 03-05-2024-2025**

<b>Agency Name: Lutheran Services Florida Miami Bridge (Homestead)</b>					<b>Monitor Name: Marcia Tavares, Lead Reviewer</b>		
<b>Contract Type : CINS/FINS</b>					<b>Region/Office: 326 NW 3 Avenue, Homestead, FL 33030</b>		
<b>Service Description: Comprehensive Onsite Compliance Monitoring</b>					<b>Site Visit Date(s): March 5-6, 2025</b>		
<b>Major Programmatic Requirements</b>	<b>Explain Rating</b>					<b>Ratings Based Upon:</b> <b>I = Interview</b> <b>O = Observation</b> <b>D = Documentation</b> <b>PTV = Submitted Prior To Visit</b> <b>(List Who and What)</b>	<b>Notes</b>  <b>Explain Unacceptable or Conditionally Acceptable:</b>
	<b>Unacceptable</b>	<b>Conditionally Acceptable</b>	<b>Fully Met</b>	<b>Exceeded</b>	<b>Not Applicable</b>		
<b>I. Administrative and Fiscal</b>							
<b>DJJ Quality Improvement Peer Reviewer</b> 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: The agency currently has four staff members certified as DJJ QI Peer reviewers: Lashonda Chavis, Citizen Fernandez, Jose Ortega and Samantha Roberts. To date, all four peers have participated in a QI review for FY24-25.	
<b>Additional Contracts</b> 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. <b>PTV</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Grant Listing for FY24-25 includes a list of seven additional funding contracts. The list includes: the name of program grant, funding source, and contract period. Additional funders are HHS Basic Center, Citrus Health– Emergency Beds, Children’s Trust, DCF Host Homes, Citrus Health – Seed to For, and CDBG Miami Dade County.	
<b>Limits of Coverage</b> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation – Miami Bridge Certificate of Insurance. General Liability through Philadelphia Indemnity Company, for limits of coverage of \$1,000,000 each \$3,000,000 aggregate,	

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	<b>Unacceptable</b>	<b>Conditionally Acceptable</b>	<b>Fully Met</b>	<b>Exceeded</b>	<b>Not Applicable</b>		
<p>\$100,000 per accident, \$100,000 per person and \$500,000 policy aggregate. Commercial General Liability with a limit of \$500,000 per occurrence, and \$1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of \$250,000 per person; with a minimum limit for bodily injury of \$500,000 per accident; with a minimum limit for property damage of \$100,000 per accident and with a minimum limit for medical payments or \$5,000-\$10,000 per person. Florida Network is listed as payee or co-payee. <b>PTV</b></p>					<p>and medical expense for \$5,000, effective through 12/27/25.</p> <p>Automobile insurance through Philadelphia Indemnity Company for combined single limits for \$1,000,000 each accident, effective through 12/27/2025.</p> <p>Workers Compensation through Accident Fund Insurance Company of America with limits of \$1,000,000 each/aggregate, effective through 6/01/2025.</p> <p>Umbrella liability through Philadelphia Indemnity Company with limits of \$1,000,000 each/aggregate, effective through 12/27/25.</p> <p>Professional Liability Abuse and Molestation through Philadelphia Indemnity Company for \$1,000,000 each and aggregate, effective through 12/27/25.</p> <p>Florida Network is listed as the certificate holder.</p>		

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<b>External/Outside Contract Compliance</b> a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Interview: During the Entrance Conference, the provider indicated there are no outstanding corrective action item(s) cited by an external funding source.	
<b>Fiscal Practice</b> 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. <b>PTV</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Accounting Procedures Manual. The agency maintains an Accounting Procedures Manual that is consistent with GAAP and provides 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.). <b>PTV</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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 further delineated by program location, Miami, or Homestead.	

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c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) – <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Observation/Documentation: Reviewed petty cash Policy and Procedure 4.32 included in section 4 of the Fiscal Manual that was last approved on October 5, 2022. The program has a petty cash fund that is used for the shelter. The shelter manager is the custodian of the petty cash which is maintained in a locked box in the manager's office. Petty Cash Custodian requests reimbursement of their funds by submitting a Petty Cash Reconciliation Request that includes all original receipts for which reimbursement is being requested along with the detailed transaction form and summary form completed. Petty Cash reconciliations are completed each month or as needed to maintain an adequate fund on hand and at the end of each fiscal and contract year.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation and documentation provided contained 2 signatures. (Disbursements/invoices are approved & monitored by management). <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Reviewed bank statements for operating accounts held with Ameris Bank and the corresponding bank reconciliations for the period July – December 2024. Bank reconciliations are processed by the finance department in the Tampa Corporate office.	

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						<p>Successful bank reconciliations were conducted within 2 weeks of receipt of bank statements. All the reconciliation worksheets were reviewed by a second party in addition to the preparer.</p> <p>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.</p>	
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. <b>PTV/ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	N/A – The agency has not purchased any items with FNYFS funds since the last time on-site.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), <u>Employee</u> IRS Form W-2 and <u>Independent Contractors</u> IRS Form 1099 forms prior to federal requirements. <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Tax Recap 3 <sup>rd</sup> and 4 <sup>th</sup> 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 third and fourth quarters of 2024 were reviewed. These	

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						reports demonstrate electronic submission of payroll taxes by or before the due dates.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. <b>PTV/ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Agency provided Budget vs. Actual report for the Miami Bridge CINS/FINS Program #304 for the fiscal period year-to-date, as of December 31, 2024. A review of the report was conducted, and variances are monitored on a monthly as well as year-to-date basis with management and the Finance Committee.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than \$750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. <b>Can obtain from FNYFS</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: The provider submitted a copy of the Financial audit conducted for year ending June 30, 2024 and 2023 for the review. The audit was completed by RSM US, LLP and was dated February 18, 2025. Per the auditors, there was no management letter or deficiency control letter issued as there were no matters required to be reported in these letters.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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	

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documents are shredded and computer hard drives are wiped prior to discarding. <b>ON SITE</b>						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. <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation A review of the Employee List Point in Time, as of October 1, 2023, was conducted and validates that all direct care staff is paid at least \$19 per hour.	

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## **CONCLUSION**

LSF Miami Bridge Homestead has met the requirements for the CINS/FINS contract as a result of full compliance with 12 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the 14 total 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](http://www.floridanetwork.org)) website forms section and download the Service Provider Corrective Action Tracking Form.



# **Florida Network of Youth and Family Services Quality Improvement Program Report**

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

March 5-6, 2025

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

**Percent of Indicators rated Satisfactory: 57.14 %**  
**Percent of Indicators rated Limited: 42.86 %**  
**Percent of Indicators rated Failed: 0 %**

### Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Limited
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: 88.89 %**  
**Percent of Indicators rated Limited: 11.11 %**  
**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	Limited
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Limited
3.07 Video Surveillance System	Limited

**Percent of Indicators rated Satisfactory: 57.14 %**  
**Percent of Indicators rated Limited: 42.86 %**  
**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: 71.43 %**  
**Percent of indicators rated Limited: 28.57 %**  
**Percent of indicators rated Failed: 0 %**

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### 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
- Shakela Minns – Regional Monitor, Department of Juvenile Justice
- Andrea Haugabook– Consultant-Forefront LLC/Florida Network of Youth and Family Services
- Karen Sanchez – Florida Keys Children Shelter
- Krizia Santana – Center for Family and Child Enrichment

## Methodology

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

### Persons Interviewed

<input type="checkbox"/> Chief Executive Officer	<input checked="" type="checkbox"/> Case Manager	<input checked="" type="checkbox"/> Nurse – Full time
<input type="checkbox"/> Chief Financial Officer	<input checked="" type="checkbox"/> Counselor Non-Licensed	<input type="checkbox"/> Nurse – Part time
<input type="checkbox"/> Chief Operating Officer	<input type="checkbox"/> Advocate	<input type="checkbox"/> 1 # Case Managers
<input type="checkbox"/> Executive Director	<input checked="" type="checkbox"/> Direct – Care Full time	<input type="checkbox"/> 2 # Program Supervisors
<input checked="" type="checkbox"/> Program Director	<input type="checkbox"/> Direct – Part time	<input type="checkbox"/> # Food Service Personnel
<input checked="" type="checkbox"/> Program Manager	<input type="checkbox"/> Direct – Care On-Call	<input type="checkbox"/> 1 # Healthcare Staff
<input checked="" type="checkbox"/> Program Coordinator	<input type="checkbox"/> Intern	<input type="checkbox"/> # Maintenance Personnel
<input checked="" type="checkbox"/> Clinical Director	<input type="checkbox"/> Volunteer	<input type="checkbox"/> 1 # Other (listed by title): Quality Specialist__
<input type="checkbox"/> Counselor Licensed	<input checked="" type="checkbox"/> Human Resources	

### Documents Reviewed

<input type="checkbox"/> Accreditation Reports	<input checked="" type="checkbox"/> Table of Organization	<input type="checkbox"/> Visitation Logs
<input checked="" type="checkbox"/> Affidavit of Good Moral Character	<input checked="" type="checkbox"/> Fire Prevention Plan	<input checked="" type="checkbox"/> Youth Handbook
<input checked="" type="checkbox"/> CCC Reports	<input checked="" type="checkbox"/> Grievance Process/Records	<input type="checkbox"/> 5 # Health Records
<input checked="" type="checkbox"/> Logbooks	<input type="checkbox"/> Key Control Log	<input type="checkbox"/> 6 # MH/SA Records
<input checked="" type="checkbox"/> Continuity of Operation Plan	<input checked="" type="checkbox"/> Fire Drill Log	<input type="checkbox"/> 9 # Personnel /Volunteer Records
<input checked="" type="checkbox"/> Contract Monitoring Reports	<input checked="" type="checkbox"/> Medical and Mental Health Alerts	<input type="checkbox"/> 10 # Training Records
<input checked="" type="checkbox"/> Contract Scope of Services	<input checked="" type="checkbox"/> Precautionary Observation Logs	<input type="checkbox"/> 12 # Youth Records (Closed)
<input checked="" type="checkbox"/> Egress Plans	<input checked="" type="checkbox"/> Program Schedules	<input type="checkbox"/> 9 # Youth Records (Open)
<input checked="" type="checkbox"/> Fire Inspection Report	<input checked="" type="checkbox"/> List of Supplemental Contracts	<input type="checkbox"/> # Other: __
<input type="checkbox"/> Exposure Control Plan	<input checked="" type="checkbox"/> Vehicle Inspection Reports	

### Observations During Review

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

### Surveys

<input type="checkbox"/> 14 # of Youth	<input type="checkbox"/> 2 # of Direct Staff	<input type="checkbox"/> # of Other	<input type="checkbox"/>
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March 5-6, 2025

## 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 holds a valid license through the Department of Children and Families for 20 beds.

### 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 **Limited**.

Indicator 1.04 Training Requirements was rated **Satisfactory**.

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 with Exception**.

Indicator 2.03 Case/Service Plan was rated **Limited**.

Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory**.

Indicator 2.05 Counseling Services was rated **Satisfactory**.

Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory**.

Indicator 2.07 Youth Records was rated **Satisfactory**.

Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory with Exception**.

Indicator 2.09 Stop Now and Plan (SNAP) was rated **Not Applicable**.

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**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 **Limited**.

Indicator 3.05 Behavior Management Strategies was rated **Satisfactory**.

Indicator 3.06 Staffing and Youth Supervision was rated **Limited**.

Indicator 3.07 Video Surveillance System was rated **Limited**.

**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) One of the eight staff (Residential Manager) hired June 2024 did not complete the Predictive Index (PI) pre-employment assessment which became effective for management/master's level in FY 23-24 (July 2023). Seven of the eight new hires were offered employment prior to completing the pre-employment suitability assessment. Two of the seven did not have evidence of scores achieved.

2) The program submitted its Annual Affidavit of Compliance with Level 2 Screening Standards to the Background Screening Unit on February 26, 2025, after the January 31st deadline.

**Indicator 1.03 - Limited**

1) One incident, CCC report #202500509, occurred 1/21/2025 at 8:00pm and was called in to CCC 1/22/2025 at 4:47pm when staff left a voicemail. CCC returned call and report was taken 01/27/2025 @ 3:38pm.

2) Fifty-three of 65 incident reports reviewed between September 2024 - March 2025 were not reviewed and signed by the supervisor at occurrence or within 24 hours as stated in the agency's internal policy titled Incident Reporting (Risk Management) approved by the Program Director 11/12/2024. A significant number of incidents observed were reviewed and signed by the Program Director more than 60 days after occurrence.

**Indicator 1.06 - Limited**

1) Two occurrences of single transports did not document supervisor's approval. None of the single transports detailed time of supervisor's approval, therefore, it could not be verified that approval occurred prior to the transportation event.

2) No evidence of check-ins were observed in the log for fourteen single transport events reviewed.

3) Nine single transport entries were not properly documented with all required elements of the indicator. Some missing elements included mileage and purpose of travel.

**Standard 2:**

**Indicator 2.03 - Limited**

1) One of the service plans reviewed was not developed within 7 working days of NIRVANA but was one day late.

2) Six closed records did not have actual completion dates, that is required by the indicator, on the service plan.

One residential record was missing youth signature. Four parental signatures were missing on the service plan and a reason was not disclosed in progress notes. Two records were missing supervisor's signatures.

3) Six of nine records reviewed did not show timely service plan reviews every 30 days.

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**Standard 3:****3.04 - Limited**

From September to November 2024, there were no entries from the Shelter Manager. Entries began on December 11th but lacked consistency. For example, the gap between December 12th and December 26th is 14 days. In January 2025, there was a gap between entries from January 2nd to January 13th (11 days). Overall, the entries for weekly reviews of the logbook failed to be conducted consistently. There is no recorded entry for the counselor reviews of the logbook, as entries did not begin until November 2024. Additionally, the dates for the reviewed entries are missing from the notes.

**3.06 - Limited**

On the boys' dorm, bed checks were documented in the logbook at 2:00 AM and 2:15 AM; however, these checks were not observed on camera. Additional entries indicating completed bed checks at 2:30 AM, 2:45 AM, and 3:00 AM were also not visible on the video footage. The video recording skips from 3:00 AM to 3:23 AM, while the logbook notes a bed check at 3:15 AM. Another video gap occurs from 3:23 AM to 3:51 AM, during which a 3:30 AM bed check is recorded in the logbook. These discrepancies suggest a lack of alignment between the documented checks and the available video footage. Per observation of the finding, the provider was advised to report the incidents to CCC. The report was accepted by CCC.

**3.07 - Limited**

- 1) Supervisory camera review entries documented in the logbook from September 2024 did not document the timeframes reviewed. One entry noted a camera review from 1/25/25 to 1/28/25 without specifying the times. The reviews occur approximately every three weeks to one month, with the following recorded dates: 09/01/24, 10/04/24, 11/15/24, 12/02/24, 12/11/24, 12/20/24, 12/28/24, 01/02/25, 01/10/25, 01/24/25, 01/28/25, 02/11/25, 02/15/25, 02/18/25, and 02/26/25.
- 2) The camera review entries in the logbook from September 2024 to the current date document the dates of reviews, but the specific times were not recorded. For instance, one entry covering the period from 01/25/25 to 01/28/25 indicated the review but did not include times. Reviews were conducted approximately every three weeks to one month, with the following dates documented: 09/01/24, 10/04/24, 11/15/24, 12/02/24, 12/11/24 (two entries), 12/20/24, 12/28/24, 01/02/25, 01/10/25, 01/24/25, 01/28/25 (two entries), 02/11/25, 02/15/25, 02/18/25, and 02/26/25.

**Standard 4:****Indicator 4.02 - Limited**

Three youth records were reviewed and found each record's observation of the youth's behavior was not documented in accordance to policy. Each youth's observation times, documented in the Note Active electronic logbook, were completed late on various dates. One youth's observation log reflected times on 12/20/2024 at 7:47pm then 9:45pm; 12/21/2024, at 2:29pm then 3:03pm, 4:57pm then 5:49pm, and 8:48pm then 10:36pm; 12/22/2024, at 6:45am then 8:00am, 8:46am then 9:31am, 9:31am then 10:28am, 10:28am then 11:01am, 1:21pm then 1:52pm; and on 12/23/2024, at 7:15am then 9:47am, 10:01am then 11:34am, 1:15pm then 1:51pm. Another youth's log documented on 2/28/2025, at 1:44am then 3:17am, 2:31pm then 3:06pm, 5:00pm then 5:34pm, and 3/2/2025, at 3:44pm then 4:17pm, 7:10pm then 7:45pm. The third youth's log reflected on 9/19/2024, at 5:44am then 6:17am, 6:17am then 7:56am, 10:00am then 11:30am; 9/20/2024, at 5:59pm then 6:05pm; on 9/21/2024, at 2:49pm then 4:25pm, 5:00pm then 5:36pm, and 6:15pm then 6:59pm; on 9/22/2024, at 7:59pm then 8:34pm, 8:34pm then 9:59pm; and on 9/23/24, at 8:47am then 9:23am.

<b>CINS/FINS QUALITY IMPROVEMENT TOOL</b>			
<b>Quality Improvement Indicators and Results:</b> Please select the appropriate outcome for each indicator for each item within the indicator.	<b>Summary/Narrative Findings:</b> The narrative write-up is a thorough summary of each assigned QI indicator, explaining how finding(s) are determined.	<b>Deficiencies/Exceptions:</b> Please add additional detailed explanations for any items that have any deficiencies or exceptions.	
<b>Standard One – Management Accountability</b>			
<b>1.01: Background Screening of Employees, Contractors and Volunteers</b>			<b>Limited</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.01</b>	<b>NO</b>	If NO, explain here: Background Screening policy is missing additional steps required by the indicator, effective 7/1/2023, regarding timeframes for re-taking the pre-employment suitability assessment, for applicants who do not pass the initial assessment.	
		The provider has a policy and procedure 1.01 - Recruitment and Background Screening of Employees, Volunteers, and Interns that was approved 12/31/2024 by the Program Director.	
All positions providing direct services to youth have successfully passed the pre-employment suitability assessment on the initial attempt prior to an offer of employment.	<b>Exception</b>	The agency previously used the Predictive Index (PI) pre-employment assessment but switched to HiMatch in February 2025. A total of eight staff were hired during the annual review. Seven of the eight staff completed the PI Assessment; one staff did not complete the assessment. Passing scores were verified for five of the seven staff who completed the assessment.	One of the eight staff (Residential Manager) hired June 2024 did not complete the Predictive Index (PI) pre-employment assessment which became effective for management/master's level in FY 23-24 (July 2023). Seven of the eight new hires were offered employment prior to completing the pre-employment suitability assessment. Two of the seven did not have evidence of scores achieved.
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.	<b>No eligible items for review</b>	All seven staff who completed the PI Assessment received passing scores.	
Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	<b>No eligible items for review</b>	None of the new hires had a break in service for more than 18 months.	

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. <i>(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.)</i>	<b>Compliance</b>	Background screenings for all eight new hires, and one intern utilized during the review period, were completed prior to hire/start dates with eligibility documented on the DJJ background screening results. There were no exemptions required.	
Five-year re-screening is completed every 5 years from the date of the last screening for all applicable employees and volunteers.	<b>No eligible items for review</b>	The program did not have any eligible re-screened staff during the review period.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	<b>Exception</b>	The program emailed its Annual Affidavit of Compliance with Level 2 Screening Standards to the Background Screening Unit; however, it was not submitted on time.	The program submitted its Annual Affidavit of Compliance with Level 2 Screening Standards to the Background Screening Unit on February 26, 2025, after the January 31st deadline.
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	<b>Compliance</b>	Proof of employment authorization from the Department of Homeland Security was obtained through E-Verify and maintained on file for the eight new hires.	
<b>1.02: Provision of an Abuse Free Environment</b>			<b>Satisfactory with Exception</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.02</b>	<b>YES</b>		
	If NO, explain here: The provider has the required policies and procedures, 1.02 Provision of Abuse Free Environment, and 1.02.01 Grievance Process that were approved by the Program Director 11/12/2024.		
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	<b>Compliance</b>	Evidence of a code of conduct policy was observed in the agency's policy and procedure manual. A signed code of conduct document is also maintained in each employee's employment record.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	<b>Compliance</b>	The agency has a process in place for reporting and documenting child abuse hotline calls. A record of seven documented child abuse hotline calls was reviewed from September 2024 - March 2025 on the following dates: 09/03/2024, 09/06/2024, 09/19/2024, 01/10/2025, 01/29/2025, 02/03/2025, 02/06/2025.	

Youth were informed of the Abuse and Contact Number	<b>Compliance</b>	Evidence that each youth is informed of the abuse contact number was observed in each youth record reviewed and the abuse hotline number is posted in conspicuous places throughout the facility.	
<b>Grievance</b>			
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.	<b>Compliance</b>	The program has an accessible and responsive grievance process for youth to provide feedback and address complaints. The Program Director began checking the grievance box as of January 2025. The Shelter Manager addresses each of the grievances unless it is against him then the Program Director addresses it. The following types of grievances were observed over the past six months: September 2024 - four (4) complaints on how staff talk to the youth, complaints on limited food options; October 2024 - seven (7) complaints of peer bullying, staff treatment and needing additional food; November 2024 - zero (0) grievances noted; December 2024 - two (2) grievances filed; January 2025 - eight (8) complaints against staff; and February 2025 - four (4) grievances filed.	
<u>Shelter only:</u> Grievances are maintained on file at minimum for 1 year.	<b>Compliance</b>	Interview with Shelter Manager indicates grievances are maintained on file for a minimum of 1 year.	
<u>Shelter only:</u> There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	<b>Compliance</b>	The program has a formal grievance process and an easily accessible locked grievance box with forms was observed in the shelter's common area.	

<p><u>Shelter only:</u> 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.</p>	<p><b>Exception</b></p>	<p>A review of the program's logbook was conducted for two consecutive weeks each month from October 2024 to March 2025, a total of six (6), Monday-Friday two-week periods (excluding holidays and weekends).</p> <p>The following is a result of the review: October 14-25, 2024, the logbook showed evidence of grievance box checks on 10/14/2024, 10/16/2024, 10/18/2024, 10/21/2024, and 10/22/2024.</p> <p>November 18-29, 2024, the logbook showed evidence of grievance box checks completed on 11/22/2024, 11/26/2024, and 11/27/2024.</p> <p>December 9-20, 2024, the logbook showed evidence of grievance box checks completed on 12/11-13/2024 and 12/16-20/2024.</p> <p>January 20-31, 2025 there were notes observed in the program's logbook that the grievance box was checked everyday.</p> <p>February 3-14, 2025, the logbook showed evidence of grievance box checks completed 2/3-2/6/2024, and 2/12-2/14/2024.</p> <p>March 3-5, 2025, it was noted that the grievance box was checked everyday.</p>	<p>Grievance box checks were not conducted for 15 of the 53 days reviewed as follows:</p> <p>October 14-25, 2024, no grievance box check was observed in the logbook on 10/15/2024, 10/17/2024, 10/22/2024, 10/23/2024, and 10/24/2024).</p> <p>November 18-29, 2024, no grievance box check was observed in the logbook on 11/18/2024, 11/19/2024, 11/20/2024, 11/21/2024, and 11/25/2024.</p> <p>December 9-20, 2024, there was no grievance box check observed on 12/9/2024 and 12/10/2024.</p> <p>February 3-14, 2025, there were no notes observed in the program's logbook that the grievance box was checked on 2/7/2024, 2/10/2024, and 2/11/2024.</p>
<p><u>Shelter only:</u> Grievances are resolved within 72 hours of being submitted or there was documentation explaining the cause for the delay in providing a resolution.</p>	<p><b>Exception</b></p>	<p>Documentation of some grievances reviewed from September 2024 - February 2025 showed evidence of resolution by the program director within 72 hours stated on each grievance form.</p>	<p>There were four occurrences observed of grievances not resolved within 72 hours of being submitted. Grievance filed 1/13/2025 showed a resolution date of 1/22/2025 by the Shelter Manager. Grievance filed 1/16/2025 showed a resolution date of 1/22/2025 by the Shelter Manager, Grievance filed 01/06/2025 resolution date 01/10/2025, Grievance filed 2/22/2025 resolution date 2/26/2025.</p>
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			

1.03: Incident Reporting		Limited	
Provider has a written policy and procedure that meets the requirement for Indicator 1.03	YES		
	If NO, explain here:		
	The provider has the required policy and procedure 1.03 Incident Reporting (Risk Management) that was approved 11/12/202 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	Exception	During the past six months there were 21 reportable incidents called in to the Central Communication Center (CCC) within two hours of the program learning of the incident.	One incident, CCC report #202500509, occurred 1/21/2025 at 8:00pm and was called in to CCC 1/22/2025 at 4:47pm when staff left a voicemail. CCC returned call and report was taken 01/27/2025 @ 3:38pm.
The program completes follow-up communication tasks/special instructions as required by the CCC	Compliance	Follow-up communication tasks/special instructions completed by the program were evident, when applicable on the CCC reports reviewed over the past six months.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	Compliance	Evidence of internal incident report forms documenting all internal incidents were reviewed from September 2024 - March 2025. All reported incidents were consistently reported to CCC as required.	
Incidents are documented in the program logs and on incident reporting forms	Compliance	Evidence of incidents were documented in the program's log and on incident reporting forms.	
All incident reports are reviewed and signed by program supervisors/ directors	Exception	A total of 65 internal incident reports for CINS/FINS youth were documented over the past six months. Incidents are recorded in the program's electronic database and routed to the supervisor for review and closure. The program has an internal policy titled Incident Reporting (Risk Management) approved by the Program Director on 11/12/2024, which requires incidents to be reviewed by the supervisor at occurrence or within 24 hours.	Fifty-three of 65 incident reports reviewed between September 2024 - March 2025 were not reviewed and signed by the supervisor at occurrence or within 24 hours as stated in the agency's internal policy titled Incident Reporting (Risk Management) approved by the Program Director 11/12/2024. A significant number of incidents observed were reviewed and signed by the Program Director more than 60 days after occurrence.
<b>Additional Comments:</b> There are no additional comments for this indicator.			

<b>1.04: Training Requirements</b> (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)		Satisfactory	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.04</b>	YES		
	If NO, explain here:		
	The provider has the required policy and procedures 1.04 - Training Requirements that was approved 11/4/2024 by the Program Director.		
<b>First Year Direct Care Staff</b>			
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: <ul style="list-style-type: none"> <li>• Agency policies and procedures</li> <li>• Behavior Management (Shelter Only)</li> <li>• Building/Facility layout</li> <li>• File Documentation/development of paperwork requirements and confidentiality</li> <li>• CCC &amp; Incident Reporting</li> <li>• Child Abuse Reporting</li> <li>• Client Intake &amp; Screening</li> <li>• Client Orientation (direct care staff training on delivering new client orientation)</li> <li>• Fire Equipment Safety</li> <li>• Medical and Mental Health Alert System (Shelter)</li> <li>• Risk Management--Including but not limited to the following:                         <ul style="list-style-type: none"> <li>- Disaster Preparedness and Emergency Response</li> <li>- First Aid/CPR</li> <li>- Universal Precautions</li> </ul> </li> <li>• Video Camera Surveillance &amp; Equipment</li> <li>• All other necessary information to orient a new hire to perform their job role and duties.</li> </ul>	<b>Compliance</b>	Four of four first year employee files reviewed contained evidence of compliance with all required pre-service training needed prior to working independently.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	<b>Compliance</b>	Four of four first year employee files reviewed contained evidence of completion of the United States Department of Justice Civil Rights and Federal Funds training within 30 days from date of hire.	
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.	<b>Compliance</b>	Four of four first year employee files reviewed contained 180, 186, 189.5 and 156.5 hours of training for the first full year.	

<p>All staff receives all mandatory training during the first 90 days of employment from date of hire.</p>	<p><b>Compliance</b></p>	<p>Four of four employee files reviewed contained all required mandatory training during the first 90 days of employment from their date of hire.</p>	
<p><b>Non Licensed Staff Assisting with Medication Distribution</b></p>			
<p>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.</p>	<p><b>Compliance</b></p>	<p>Three of four applicable employees completed in-person training from a Registered Nurse prior to administering medication in the shelter. One employee file reviewed was not applicable due to being a community counseling employee.</p>	
<p><b>Staff that are Utilizing NETMIS</b></p>			
<p>Any staff that is utilizing NETMIS has evidence of completing NetMIS Training in their training file.</p>	<p><b>No eligible items for review</b></p>	<p>Four of four employee files reviewed were not applicable as they do not have access or do data entry into NetMIS. Therefore, there were no eligible employees required to complete this training.</p>	
<p><b>Staff Participating in Case Staffing &amp; CINS Petitions (within the first year of employment BUT no later 7/1/24 for previous staff)</b></p>			
<p>Documentation of instructor-led FL Statute 984 CINS Petition Training by a local DJJ Attorney <u>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).</u></p>	<p><b>No eligible items for review</b></p>	<p>Four of four employee files reviewed do not participate in case staffing and CINS petitions and therefore are not required to complete this training.</p>	
<p><b>Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)</b></p>			
<p>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).</p>	<p><b>Compliance</b></p>	<p>Two of two non-licensed mental health clinical staff person's training files were reviewed and found to be in compliance with completion of training in Assessment of Suicide Risk prior to administering a suicide assessment.</p>	
<p><b>In-Service Direct Care Staff</b></p>			
<p>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.</p>	<p><b>Compliance</b></p>	<p>Four of four in-service employee training files reviewed contained all the required annual or two-year mandatory refresher Florida Network, SkillPro, or other job-related training within the required timeframe.</p>	

Community Counseling Direct Care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.	No eligible items for review	All in-service files reviewed for this QI review period were shelter direct care staff.	
Shelter Program Direct Care staff completes 40 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually ( <i>E.g. the program has a DCF child caring license</i> ).	Compliance	Four of four shelter program direct care staff training files reviewed contained 96, 65.5, 89, and 78.5 hours of mandatory refresher Florida Network, SkillPro, and job-related training.	
<b>Required Training Documentation</b>			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	Compliance	Evidence of the agency's training plan was observed to include all required training topics including both pre-service and in-service trainings.	
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 a designated staff member responsible for managing all employee training files and conducting routine tracking and review of the files to ensure compliance.	
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 provided evidence of individual training files with each employee file containing a training log similar to the Florida Network's training log with all required elements, including certificates of completion and related documentation.	
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:		Seven of eight employee training files reviewed have evidence of completion of Naloxone training within the required timeframe. One employee has until June 2025 to complete the training.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>1.05 - Analyzing and Reporting Information</b>			<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.05</b>	<b>YES</b>		
	If NO, explain here:		
	The provider has the required policy and procedure 1.05 - Analyzing and Reporting Information, that was approved on 11/12/2024 by the Program Director. The agency also has a Quality Improvement Plan for FY2024-2025.		

<p>Case record review reports demonstrate reviews are conducted quarterly, at a minimum. <i>(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.)</i></p>	<p><b>Compliance</b></p>	<p>Case record reviews are conducted by both the Quality Management Specialist (QMS) and the clinical program staff. Each record review is documented on the File Review Tool . The last two case record reviews were conducted in September 2024 for the reporting period January-July 2024, and February 2025, for a total of 22 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 documented on a Summary Report for each period and also reported on the CQI Monthly Spreadsheet Companion Report that is reviewed at the monthly CQI meetings.</p>	
<p>The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum</p>	<p><b>Compliance</b></p>	<p>The agency has a committee that meets monthly to discuss infection control, safety, and risk management. Monthly meetings were observed to be held September 2024-February 2025. Incidents and accidents are entered in real time into the agency's Converge Point electronic platform. All staff has access to enter incidents directly into the platform. 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.</p>	
<p>The program conducts an annual review of customer satisfaction data</p>	<p><b>Compliance</b></p>	<p>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.</p>	

<p>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.</p>	<p><b>Compliance</b></p>	<p>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.</p>	
<p>The program has a process in place to review and improve accuracy of data entry &amp; collection</p>	<p><b>Compliance</b></p>	<p>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.</p>	
<p>There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.</p>	<p><b>Compliance</b></p>	<p>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.</p>	
<p>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.</p>	<p><b>Compliance</b></p>	<p>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.</p>	
<p>There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.</p>	<p><b>Compliance</b></p>	<p>The agency has an Associate Vice President Quality Assurance and Compliance who leads the development, implementation, documentation, evaluation, and promotion of continuous improvement practices and systems. LSF Miami Bridge also has a QMS who is responsible for oversight at the local level. Processes are in place and established in the PQI plan to collect data and identify areas needing improvement. Should negative trends be observed, a corrective action will be implemented as a priority issue to be addressed and is monitored by the compliance staff as well as the program management team.</p>	

**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 provider has the required policy and procedures 1.06 - Transportation and Vehicle Management that was approved 11/19/2024 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	Employee names and drivers' license information is given to the Training Coordinator to validate motor vehicle record. The record is checked by the Training Coordinator and the employee is added to the approved list to drive clients in agency vehicles. Evidence of driver training was observed in training files reviewed on-site and a list of approved drivers was provided.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	Compliance	A list prepared as of March 1, 2025 verified 31 approved agency drivers having valid Florida driver's license. Proof of coverage under the company's insurance policy was provided.	
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 3 <sup>rd</sup> party is NOT present in the vehicle while transporting	Compliance	A review of the agency's transportation policy shows the agency prohibits the transportation of a client without maintaining at least one other passenger in the vehicle during the trip and includes exceptions in the event that a 3 <sup>rd</sup> party is not present in the vehicle while transporting.	
In the event that a 3 <sup>rd</sup> 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 transportation policy states, in the event that a 3 <sup>rd</sup> party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior.	
The 3 <sup>rd</sup> party is an approved volunteer, intern, agency staff, or other youth	Compliance	The agency's transportation policy states, the 3 <sup>rd</sup> party is 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 15 single transport events occurred between September 1, 2024 and March 6, 2025. Thirteen of 15 single transport events showed a supervisor name as an indication of approval for the transport. The program staff reported that the Shelter Manager approves all single transportation events and the approval is logged in the program's logbook by the staff obtaining the approval.	Two occurrences of single transports did not document supervisor's approval. None of the single transports detailed time of supervisor's approval, therefore, it could not be verified that approval occurred prior to the transportation event.

<p>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.</p>	<p><b>Exception</b></p>	<p>Fifteen single transportation events observed in the agency's logbook were reviewed from September 1, 2024 - March 6, 2025. One single transport event showed evidence of time of departure from the shelter and time of arrival at the destination.</p>	<p>No evidence of check-ins were observed in the log for fourteen single transport events reviewed.</p>
<p>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.</p>	<p><b>Exception</b></p>	<p>Fifteen single transportation events observed in the agency's logbook were reviewed from September 1, 2024 - March 6, 2025. Each entry included the name of the driver and location.</p>	<p>Nine single transport entries were not properly documented with all required elements of the indicator. Some missing elements included mileage and purpose of travel.</p>
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			
<p><b>1.07 - Outreach Services</b></p>			<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 1.07</b></p>	<p><b>YES</b></p>		
	<p>If NO, explain here:</p>		
	<p>The provider has the required policy and procedures 1.07 - Outreach Services and Interagency Agreements that was approved by the Program Director on 11/12/2024.</p>		
<p>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.</p>	<p><b>Compliance</b></p>	<p>The Shelter Manager is designated to participate in local DJJ board, Circuit and Council meetings. Evidence of attendance over the past six months was observed.</p>	
<p>The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.</p>	<p><b>Compliance</b></p>	<p>The program maintains written agreements with community partners which include services provided and a comprehensive referral process. The program also has a comprehensive Outreach Plan for 2024-2025. The plan identifies five primary goals and outcomes achieved through various tactics, and addresses ways to assure stakeholder participation, ways to inform and educate the community about issues and trends facing families and youth in Miami-Dade County, educating youth of the inherent risks and dangers of engaging in runaway, truant and ungovernable behavior, ways to increase awareness of and access to Miami Bridge's continuum of services and referral network to address the needs of at-risk youth.</p>	

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.	<b>Compliance</b>	Evidence of 64 outreach events was reviewed on a summary printed from NetMIS that included: the title, date, duration, zip code, location, estimated number of people reached, modality, target audience and topic.	
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<p>The program has designated staff that conducts outreach which is defined in their job description.</p>	<p><b>Compliance</b></p>	<p>The Youth and Community Engagement Coordinator is the designated staff that conducts outreach as defined and observed in her job description. The job description for the Youth and Community Engagement Coordinator included essential functions such as: working with the Program Director to develop a community engagement program with a plan to include agreed goals, priority target audiences; Identify, maintain and strengthen links with relevant local community organizations, community and faith groups and stakeholders.</p>	
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			
<p><b>Standard Two – Intervention and Case Management</b></p>			
<p><b>2.01 - Screening and Intake</b></p>			<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 2.01</b></p>	<p><b>YES</b></p>		
	<p>If NO, explain here:</p>		
	<p>The provider has the required policy and procedures 2.01 - Screening and Intake Assessment that was approved 11/12/2024 by the Program Director.</p>		
<p><b>Shelter youth:</b> Eligibility screening form is completed immediately for all shelter placement inquiries.</p>	<p><b>Compliance</b></p>	<p>For all five residential files reviewed, the eligibility screening form was completed immediately for all shelter placement inquiries.</p>	
<p><b>Community counseling:</b> Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.</p>	<p><b>Compliance</b></p>	<p>All five community counseling files reviewed showed the eligibility screening form was completed within three business days of referral by a trained staff using the Florida Network screening form.</p>	
<p>There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.</p>	<p><b>Compliance</b></p>	<p>All files reviewed showed evidence that all referrals for service were screened for eligibility and logged in NETMIS within 72 hours of screening completion.</p>	
<p>Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians</p>	<p><b>Compliance</b></p>	<p>All ten files reviewed demonstrated the counselor discussed the intake process, the available service options, and rights and responsibilities of youth and parent/guardian.</p>	
<p>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</p>	<p><b>Compliance</b></p>	<p>All ten files reviewed demonstrated the counselor also discussed the possible actions occurring throughout involvement with CINS/FINS services including case staffing committee, CINS petition and CINS adjudication, with the youth and parent/guardian.</p>	
<p>During intake, all youth were screened for suicidality and correctly assessed as required if needed.</p>	<p><b>Compliance</b></p>	<p>All residential and community counseling youths were screened and correctly assessed as required during Intake.</p>	

<b>Additional Comments:</b> There are no additional comments for this indicator.			
<b>2.02 - Needs Assessment</b>		<b>Satisfactory with Exception</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 2.02</b>		<b>YES</b>	
		If NO, explain here:	
		The provider has the required policy and procedures 2.02 - Needs Assessment that was approved on 11/12/2024 by the Program Director.	
Shelter Youth: NIRVANA is initiated within 72 hours of admission	<b>Compliance</b>	All five shelter files reviewed included a NIRVANA that was completed 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 <b>OR</b> updated, if most recent assessment is over 6 months old	<b>Compliance</b>	All five community counseling files reviewed had NIRVANA initiated at intake and completed within 2 to 3 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.	<b>Compliance</b>	All residential and community counseling youth files reviewed contained a NIRVANA Assessment that is signed by a supervisor and documented in the youth's file.	
(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.	<b>Compliance</b>	All five shelter files reviewed contained the NIRVANA Self-Assessment (NSR) that 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.	<b>Exception</b>	Six closed records were reviewed. NIRVANA post assessments were completed at discharge for three of the six records.	NIRVANA post assessments were not completed at discharge for three of the six applicable youth records reviewed.
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	<b>No eligible items for review</b>	A NIRVANA RE-ASSESSMENT was not needed or applicable for any of the youth records reviewed.	
All files include the interview guide and/or printed NIRVANA.	<b>Compliance</b>	All files reviewed included the interview guide and or a printed NIRVANA.	
<b>Additional Comments:</b> There are no additional comments for this indicator.			

2.03 - Case/Service Plan		Limited	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 2.03</b>		YES	
		If NO, explain here:	
		The provider has the required policy and procedures 2.03 - Case Service Plan Development that was approved on 11/12/2024 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 had a service plan 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	Exception	Nine of the ten youth records had a service plan developed within seven working days of NIRVANA.	One of the service plans reviewed was not developed within 7 working days of NIRVANA but was one day late.
<b>Case plan/service plan includes:</b> 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	Exception	All ten files reviewed demonstrated individualized and prioritized need(s) and goal(s) identified by the NIRVANA, as well as service type, location, person(s) responsible, signature of counselor and target date(s) for completion. Nine of the service plans stated the implementation date. One record was missing initiation date; however, based on the signatures from supervisor and counselor there is evidence that the plan was initiated.	Six closed records did not have actual completion dates, that is required by the indicator, on the service plan. One residential record was missing youth signature. Four parental signatures were missing on the service plan and a reason was not disclosed in progress notes. Two records were missing supervisor's signatures.
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	Exception	Three of nine applicable youth records reviewed demonstrated service plan reviews were conducted every 30 days for the first three months.	Six of nine records reviewed did not show timely service plan reviews every 30 days.
<b>Additional Comments: There are no additional comments for this indicator.</b>			
2.04 - Case Management and Service Delivery		Satisfactory	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 2.04</b>		YES	
		If NO, explain here:	
		The provider has the required policy and procedures 2.04.01-Service Follow up and Aftercare that was approved on 11/12/2024 by the Program Director.	
Counselor/Case Manager is assigned	Compliance	Each of the ten files demonstrated a counselor/case manager was assigned to work with the youth/family from case assignment to termination.	

<p>The Counselor/Case Manager completes the following as applicable:</p> <ol style="list-style-type: none"> <li>1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs</li> <li>2. Coordinates service plan implementation</li> <li>3. Monitors youth's/family's progress in services</li> <li>4. Provides support for families</li> <li>5. Monitoring progress of court ordered youth in shelter</li> <li>6. Makes referrals to the case staffing to address problems and needs of the youth/family</li> <li>7. Accompanies youth and parent/guardian to court hearings and related appointments</li> <li>8. Refers the youth/family for additional services when appropriate</li> <li>9. Provides case monitoring and reviews court orders</li> <li>10. Provides case termination notes</li> <li>11. Provides follow-up after 30 days post discharge</li> <li>12. Provides follow-up after 60 days post discharge</li> </ol>	<p><b>Compliance</b></p>	<p>All ten records reviewed demonstrated coordination of service plan implementation based on the youth's/family's problems and needs. It was also evident the case worker monitored youth's/family's progress in services, provided support for families when needed, and referred the youth/family for additional services when appropriate. Thirty and 60 day follow ups post discharge were completed timely in five applicable files.</p>	
<p>The program maintains written agreements with other community partners that include services provided and a comprehensive referral process</p>	<p><b>Compliance</b></p>	<p>The program maintains written agreements with other community partners such as Baptist Health, therapists, and other diverse community partners that collaborate with LSF Miami Bridge South that include services provided and a comprehensive referral process.</p>	
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			
<p><b>2.05 - Counseling Services</b></p>			<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 2.05</b></p>	<p><b>YES</b></p> <p>If NO, explain here:</p> <p>The provider has the required policy and procedures 2.05 - Counseling Services and Family Involvement that was approved 11/12/2024 by the Program Director.</p>		
<p><b>Shelter Program</b></p>			
<p>Shelter programs provides individual and family counseling</p>	<p><b>Compliance</b></p>	<p>LSF Miami Bridge provides individual and family counseling. Counseling notes in the five residential youth records. demonstrate individual and family counseling services were provided.</p>	

<p>Group counseling sessions held a minimum of five days per week</p>	<p><b>Compliance</b></p>	<p>Provision of group sessions was reviewed during the review period for six randomly selected weeks. Groups were held for a minimum of five times per week for all six weeks reviewed. Reviewer observed a group during the onsite visit. The group was conducted well and the topic discussed control and how to identify what you can control and what you cannot control. It lasted for an hour and the youth had an assignment of tracing their hands to explain five things they are able to control.</p>	
<p>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</p>	<p><b>Compliance</b></p>	<p>Groups are conducted predominantly by staff members and occasionally, youth/guests. Group counseling sessions consist of a clear leader or facilitator, relevant topic, opportunity for youth to participate, and lasts 30 minutes or longer.</p>	
<p>Documentation of groups must include date and time, a list of participants, length of time, and topic.</p>	<p><b>Compliance</b></p>	<p>The program maintains documentation of groups in a binder, organized by months, including date and time, a list of the participants, length of time of class and topic.</p>	
<p><b>Community Counseling</b></p>			
<p>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.</p>	<p><b>Compliance</b></p>	<p>The community counseling files reviewed displayed evidence the community counseling program provides therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the office, in youth's home, a community location, 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.</p>	
<p><b>Counseling Services</b></p>			
<p>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.</p>	<p><b>Compliance</b></p>	<p>There is evidence in the files reviewed that 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.</p>	
<p>Maintain individual case files on all youth and adhere to all laws regarding confidentiality.</p>	<p><b>Compliance</b></p>	<p>All of the youth records were maintained in individual youth records created in Lauris online with adherence to all laws regarding confidentiality.</p>	
<p>Case notes maintained for all counseling services provided and documents youth's progress.</p>	<p><b>Compliance</b></p>	<p>Case notes are maintained in all of the records indicating the youth's progress as well as case notes for all services provided.</p>	

On-going internal process that ensures clinical reviews of case records and staff performance.	<b>Compliance</b>	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.	<b>No eligible items for review</b>	None of the intakes for the records reviewed were conducted through virtual means.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>2.06 - Adjudication/Petition Process</b>			<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 2.06</b>	<b>YES</b>		
	If NO, explain here:		
	The provider has the required policy and procedures 2.06 - CINS Adjudication and Petition Process that was approved 11/12/2024 by the Program Director.		
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	<b>Compliance</b>	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	<b>Compliance</b>	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	<b>Compliance</b>	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 other entity. There is a designated staff who schedules and coordinates the case	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	<b>Compliance</b>	The program does have an internal procedure for the case staffing process, including a schedule for committee meetings. Members of the committee are notified via email when a case staffing is scheduled to be convened.	

The youth and family are provided a new or revised plan for services	No eligible items for review	There were no eligible youth for case staffing during the annual review period.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	No eligible items for review		
If applicable, the program works with the circuit court for judicial intervention for the youth/family	No eligible items for review		
Case Manager/Counselor completes a review summary prior to the court hearing	No eligible items for review		
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>2.07 - Youth Records</b>			<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 2.07</b>	<b>YES</b>		
	If NO, explain here:		
	The provider has the required policy and procedures 2.07 - Youth Manual and Electronic Medical Records that was approved 11/12/2024 by the Program Director.		
All records are clearly marked 'confidential'.	<b>Compliance</b>	The program uses Lauris online electronic file system instead of manual files. All additional youth record documentation provided during the review were clearly marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	<b>Compliance</b>	Closed youth records are kept in a secured and centralized location in the north Miami office. Active 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"	<b>Compliance</b>	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	<b>Compliance</b>	The Lauris Online electronic records are organized in a consistent manner to maintain chronology and order for the various sections of the youth record.	

<p>SHELTER FILES contain the following: Table of Contents that outlines documents in each section:</p> <ul style="list-style-type: none"> <li>•Screening</li> <li>•Informed Consent</li> <li>• Photograph of the youth</li> <li>• Shelter Intake Form</li> <li>• Suicide Assessment (if needed)</li> <li>• NIRVANA Self Report (NSR)</li> <li>• NIRVANA full Assessment</li> <li>• Plan of Service</li> <li>• Chronological Notes</li> <li>• Medication Inventory Form</li> <li>• Approved contact list</li> <li>• Copies of referrals made &amp; Follow-Up (if needed)</li> <li>• Discharge summary once case is closed</li> </ul>	<p><b>Compliance</b></p>	<p>All residential files that were reviewed contained the Table of Contents that outlined documents in each section which included, screening, informed consent, photograph of youth, shelter intake form, Suicide Assessment, Nirvana Self Report, Nirvana full Assessment, plan of service, Chronological notes, Medication inventory form, approved contact list, copies of referrals made and follow up and discharge summary once case is closed.</p>	
<p>COMMUNITY COUNSELING FILES contain the following: Table of Contents that outlines documents in each section:</p> <ul style="list-style-type: none"> <li>• Screening</li> <li>• Informed Consent</li> <li>• Community Counseling Intake Form</li> <li>• Suicide Assessment (if needed)</li> <li>• NIRVANA full Assessment</li> <li>• Plan of Service</li> <li>• Chronological case notes</li> <li>• Copies of referrals made &amp; Follow-Up (if needed)</li> <li>• Discharge summary once the case is closed</li> </ul>	<p><b>Compliance</b></p>	<p>All community counseling files that were reviewed contained the Table of Contents that outlined documents in each section which included screening, informed consent, community counseling intake form, Suicide assessment, Nirvana full assessment, plan of service, Chronological case Notes, copies of referral made and follow up and a discharge summary once the case is closed.</p>	
<p>All records kept electronically, are maintained securely and can be made immediately available upon request for audit purposes.</p>	<p><b>Compliance</b></p>	<p>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.</p>	
<p>Records are retained for the duration of the time specified by the contract.</p>	<p><b>Compliance</b></p>	<p>Per the agency's policy and procedure, records are retained for the required duration of the contract.</p>	
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			

<b>2.08 - Specialized Additional Program Services</b>		<b>Satisfactory with Exception</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 2.08</b>	<b>YES</b>		
	If NO, explain here:		
	The provider has the required policy and procedure 3.07 - Special Populations, that was approved on 11/12/2024 by the Program Director.		
<b>Staff Secure</b>			
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")	<b>No eligible items for review</b>	LSF Miami Bridge Homestead 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	<b>No eligible items for review</b>		
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	<b>No eligible items for review</b>		
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	<b>No eligible items for review</b>		
Agency provides a written report for any court proceedings regarding the youth's progress	<b>No eligible items for review</b>		
<b>Domestic Minor Sex Trafficking (DMST)</b>			
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")	<b>No eligible items for review</b>	LSF Miami Bridge Homestead 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		
<b>Domestic Violence</b>			
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 two applicable discharges.	

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<p>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.</p>	<p><b>Compliance</b></p>	<p>Two of the three youth had a length of stay in the shelter, exceeding 21 days. Documentation verified the DV Respite did not exceed 21 days and the two youth were transitioned to CINS/FINS.</p>	
<p>Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home</p>	<p><b>Exception</b></p>	<p>The case plans for two of the three youth reflected goals for anger management and family coping skills.</p>	<p>One of three DV records reviewed has history of violence and SA; however, neither issue was addressed on the youth's service plan.</p>
<p>All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements</p>	<p><b>Compliance</b></p>	<p>All three files reviewed demonstrated youth participated in services consistent with other general CINS/FINS population while in care.</p>	
<p><b>Probation Respite</b></p>			
<p>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")</p>	<p><b>Yes</b></p>	<p>One probation respite youth was served during the annual review.</p>	
<p>All probation respite referrals are submitted to the Florida Network.</p>	<p><b>Compliance</b></p>	<p>Documentation supported the referral was submitted to the Florida Network for approval.</p>	
<p>All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.</p>	<p><b>Compliance</b></p>	<p>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.</p>	
<p>Data entry into NetMIS and JJIS within (3) business days of intake and discharge</p>	<p><b>Compliance</b></p>	<p>A review of NetMIS verified data entry was completed within three business days of intake and discharge.</p>	
<p>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.</p>	<p><b>Compliance</b></p>	<p>Length of stay for the youth was 29 days, which did not exceed the 30 day timeframe required.</p>	
<p>All case management and counseling needs have been considered and addressed</p>	<p><b>Compliance</b></p>	<p>The case plan for the youth reflected goals for addressing youth's behavior and counseling services needed.</p>	
<p>All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements</p>	<p><b>Compliance</b></p>	<p>Youth record demonstrated the youth participated in services consistent with other general CINS/FINS population while in care.</p>	
<p><b>Intensive Case Management (ICM)</b></p>			
<p>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")</p>	<p><b>Not Applicable</b></p>	<p>LSF Miami Bridge does not have a contract to provide ICM services.</p>	

<p>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.</p>	<p><b>Not Applicable</b></p>		
<p>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.</p>	<p><b>Not Applicable</b></p>		
<p>Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements</p>	<p><b>Not Applicable</b></p>		
<p>Service/case plan demonstrates a strength-based, trauma-informed focus</p>	<p><b>Not Applicable</b></p>		
<p>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</p>	<p><b>Not Applicable</b></p>		
<p><b>Family and Youth Respite Aftercare Services (FYRAC)</b></p>			
<p>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")</p>	<p><b>Not Applicable</b></p>		
<p>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.</p>	<p><b>Not Applicable</b></p>		
<p>Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office</p>	<p><b>Not Applicable</b></p>		

<p>Intake and initial assessment sessions meets the following criteria:</p> <ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan.</li> </ul>	<p><b>Not Applicable</b></p>		
<p>Life Management Sessions meets the following criteria:</p> <ul style="list-style-type: none"> <li>a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit</li> <li>b. Services are highly supportive, individualized, and flexible and require a “whole family” approach to dealing with the problems affecting the youth and family.</li> </ul>	<p><b>Not Applicable</b></p>		
<p>Individual Sessions:</p> <ul style="list-style-type: none"> <li>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.</li> <li>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.</li> </ul>	<p><b>Not Applicable</b></p>		
<p>Group Sessions:</p> <ul style="list-style-type: none"> <li>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.</li> <li>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</li> </ul>	<p><b>Not Applicable</b></p>		

There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	<b>Not Applicable</b>		
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	<b>Not Applicable</b>		
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	<b>Not Applicable</b>		
All data entry in NetMIS is completed within 3 business days as required.	<b>Not Applicable</b>		
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>2.09- Stop Now and Plan (SNAP)</b>			<b>Not Applicable</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 2.09</b>	N/A		
	If NO, explain here:		
	LSF Miami Bridge is not a SNAP provider.		
<b>SNAP Clinical Groups Under 12</b>			
Youth are screened to determine eligibility of services with the required documents: a. Florida Network Youth Screening Form b. SNAP® Brief Intake Screening Checklist	<b>Not Applicable</b>	LSF Miami Bridge is not contracted to provide SNAP services.	
All files contain <b>each</b> 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	<b>Not Applicable</b>		
The NIRVANA was completed at initial intake, or within two sessions.	<b>Not Applicable</b>		
There is evidence of the completed the Pre - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	<b>Not Applicable</b>		

There is evidence of the completed Pre - TOPSE is completed by the caregiver and is located within the file.	<b>Not Applicable</b>		
There is evidence of the following documents located within the file: a. SNAP® Parent Goal Sheet b. Child Way To Go Goal Sheet <i>(This may be in progress for open files but is required for all closed files.)</i>	<b>Not Applicable</b>		
<b>SNAP Clinical Groups Under 12 - Discharge</b>			
There is evidence of the completed the Post - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	<b>Not Applicable</b>		
There is evidence of the completed Post - TOPSE is completed by the caregiver and is located within the file.	<b>Not Applicable</b>		
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	<b>Not Applicable</b>		
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	<b>Not Applicable</b>		
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	<b>Not Applicable</b>		
<b>SNAP Clinical Groups for Youth 12-17</b>			
Youth are screened to determine eligibility of services using the Florida Network Youth Screening Form.	<b>Not Applicable</b>		
The file contains the completed Florida Network Community Counseling Intake Form and is located within the file.	<b>Not Applicable</b>		
The Consent to Treatment and Participation in Research Form is completed, signed by the parent/guardian before receiving services, and located within the file.	<b>Not Applicable</b>		

The NIRVANA was completed at initial intake, or within two sessions.	<b>Not Applicable</b>		
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.	<b>Not Applicable</b>		
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.	<b>Not Applicable</b>		
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.	<b>Not Applicable</b>		
All closed files contained evidence in the file a NIRVANA was completed at discharge.	<b>Not Applicable</b>		
<b>SNAP for Schools &amp; Communities</b>			
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. <i>(This must include a total of 13 attendance sheets for a full cycle)</i>	<b>Not Applicable</b>		
The program maintained evidence of a completed 'Way to Go Goal' Sheet within the file.	<b>Not Applicable</b>		
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	<b>Not Applicable</b>		
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	<b>Not Applicable</b>		

<p>There is evidence of the SNAP® for Schools &amp; Communities Feedback Form completed by the supervisory adult responsible for the support of the youth receiving services and entered into NetMIS.</p>	<p><b>Not Applicable</b></p>		
<p>There is evidence of one (1) Fidelity Adherence Checklist completed per classroom for the 13-week classroom sessions which is located in the file.</p>	<p><b>Not Applicable</b></p>		
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			
<p><b>Standard Three – Shelter Care</b></p>			
<p><b>3.01 - Shelter Environment</b></p>			<p><b>Satisfactory with Exception</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 3.01</b></p>	<p><b>YES</b></p>		
	<p>If NO, explain here:</p>		
	<p>The provider has the required policy and procedure 3.01 - Shelter Environment that was approved 10/31/24 by the Program Director.</p>		
<p><b>Facility Inspection:</b>                  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.</p>	<p><b>Exception</b></p>	<p>A tour of the facility was conducted and found to be in fair condition overall. Youth have access to bathrooms in each dorm equipped with three showers, dressing rooms, and three toilet stalls, and vanity area with sinks. The interior of the facility is well lit throughout and adequate for tasks performed. A large dumpster is located near the exit of the campus and was observed to be covered during the visit. Doors are secure with key access required. The egress map was observed in the common area, down the hall by the administrative offices, and in both the male and female dorms. The DJJ incident reporting number was visible in the shelter manager's office, staff office, common area, and both the male and female dorms. Grievance forms, the DJJ incident reporting number, and the abuse hotline information was posted in the common area and staff office.</p>	<p>During the tour, a few areas were observed that could benefit from attention. Debris such as leaves and scattered tree branches were found near the entrance to the facility and could be cleared to improve both safety and appearance. Graffiti was observed in the female dorm and some carved graffiti in the client toilet. The building may benefit from a fresh coat of paint, and the floors appear to be in need of maintenance to improve cleanliness and presentation. A leaning fence on the property requires some attention for safety purposes. Additionally, the metal rings in both the male and female showers could pose a safety concern and needs to be replaced.</p>

<p><b>Facility Inspection:</b> 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.</p>	<p><b>Exception</b></p>	<p>The program uses two minivans to transport youth. Both vehicles, two GMC vans, one red and one green, were equipped with first aid kits, fire extinguishers, glass breaker, flashlights, and seat belt cutter.</p>	<p>A total of seven vehicles were randomly checked during the tour. One vehicle, a Buick, was found to be left unlocked.</p>
<p><b>Facility Inspection:</b>  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.</p>	<p><b>Exception</b></p>	<p>Chemicals are stored in a locked closet adjacent to the kitchen. A perpetual inventory is the primary means of maintaining the current and real-time inventory and has been done weekly during the past 6 months. The provider utilizes a chemical dispensation system that is mounted in the chemical closet and dispenses a specific ratio of concentrated professional cleaning chemicals with water into an appropriate container to create a ready-to-use product. The location of the Material Safety Data Sheets (MSDS) is in the kitchen, stored securely in the locked chemical closet. A sampling of chemical inventories were reviewed for the periods September 1-7, 2024, October 7-13, 2024, and November 18-24, 2024.</p>	<p>There were some inventory discrepancies noted, specifically for the products Professional Unscented Softener and Tide Professional Detergent. Additionally, it was observed that the following chemicals were missing their corresponding MSDS sheets: Spic &amp; Span Spray &amp; Glass Cleaner and Clean on the Go.</p>
<p><b>Facility Inspection:</b>  Washer/dryer are operational &amp; 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.</p>	<p><b>Compliance</b></p>	<p>The washer and dryer were in good condition, with no excess lint found, and the dryer was in use at the time of inspection. A copy of the current DCF license was not posted in the office at the time of the tour; however, the Shelter Manager provided the license, which is effective from April 1, 2024, to March 31, 2025. The program has dormitory style rooming and both the boys and girls dorm rooms were well maintained and did not contain contraband. Youth are assigned individual beds and lockers that are kept locked, to keep personal belongings. All beds had a pillow and were covered with bed sheets and a comforter.</p>	
<p><b>Additional Facility Inspection Narrative (if applicable)</b></p>			

<p><b>Fire and Safety Health Hazards:</b>                  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).</p>	<p><b>Exception</b></p>	<p>The annual facility fire inspection was conducted by Miami Dade Fire Rescue Department on 2/26/2024 and resulted in a satisfactory inspection. The facility is in compliance with local fire safety guidelines.</p> <p>Fire drills and emergency drills were reviewed for the past six months. All fire drills October - December 2024 and January 2025 met the 2-minute evacuation time requirement. All emergency drills in December 2024, and January - February 2025 were completed on time.</p>	<p>In September 2024, two out of three drills exceeded the 2-minute evacuation timeframe, and in February 2025, two drills were also not completed within this limit, with one drill on February 28, 2025, missing the evacuation time. Regarding emergency drills, there was no drill for the 2nd shift in October, and one drill in November was missing the date and/or time.</p>
<p><b>Fire and Safety Health Hazards:</b>                  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.</p>	<p><b>Compliance</b></p>	<p>The agency has a current Satisfactory Residential Group Care inspection report from the Department of Health, with the certificate printed on 03/12/2024 and valid through March 31, 2025. Additionally, the agency holds a Satisfactory Food Service inspection report, with food menus posted, up-to-date, and annually signed by a Licensed Dietician. Food storage practices are in compliance, with cold food properly stored, marked, and labeled, and leftovers stored in containers with dates. The fridge temperature is maintained at 38°F, while the freezer temperature is at 15°F. Fire safety extinguishers in the agency vehicles were inspected on 03/23/2023 and are valid through March 31, 2025. The refrigerators and freezers are clean and maintained at the required temperatures, and all small and medium-sized appliances are operable and clean for use as needed.</p>	
<p><b>Additional Fire and Safety Health Hazards Narrative (if applicable)</b></p>			
<p><b>Youth Engagement</b></p>			

<p>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.</p> <p>b. At least one hour of physical activity is provided daily.</p> <p>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.</p> <p>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.</p> <p>e. Daily programming schedule is publicly posted and accessible to both staff and youth.</p>	<p><b>Compliance</b></p>	<p>During the observation period, youth were actively engaged in a variety of constructive activities. Some participated in a volleyball game, demonstrating teamwork and positive peer interaction. Others were observed completing homework, reflecting a focus on academic responsibilities, while a few were watching television in a relaxed and supervised setting. The agency provides a well structured and engaging environment for youth, as outlined in the weekly activity schedule. Youth are actively involved in meaningful activities such as life skills training, arts and crafts, volunteering, and more, twice daily. Quiet time is offered from 2:00PM to 3:00PM daily, as indicated on the schedule, allowing youth a period for relaxation. Homework time is scheduled from 3:00PM to 5:15PM, during which youth have the opportunity to complete assignments. Additionally, youth are provided with at least one hour of physical activity each day, and are encouraged to participate in a variety of faith-based activities, with non-punitive alternatives available for those who do not wish to participate. The daily programming schedule, which includes these activities, is posted on the bulletin board in the common area where it is easily visible to both staff and youth. This structured programming ensures minimal idle time and promotes a well-rounded, productive routine for the youth.</p>	
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			
<p><b>3.02 - Program Orientation</b></p>			<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 3.02</b></p>	<p><b>YES</b></p> <p>If NO, explain here:</p> <p>The agency has the required policy and procedures 3.02 - Program Orientation that was approved 10/31/2024 by the Program Director.</p>		
<p>Youth received a comprehensive orientation and handbook provided within 24 hours</p>	<p><b>Compliance</b></p>	<p>All five youth records reviewed have an orientation checklist indicating the youth received a comprehensive orientation within 24 hours.</p>	

<p>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</p>	<p><b>Compliance</b></p>	<p>All files have a checklist, with the staff and youth's signature, indicating topics covered during orientation such as the program's disciplinary action, program rules, grievance procedure, emergency procedures, the contraband policy, tour of facility, and how to contact the abuse hotline. Suicide prevention and room assignment are not listed on the checklist but are reviewed during intake and documented on separate forms.</p>	
<p>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</p>	<p><b>Compliance</b></p>	<p>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.</p>	
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>			
<p><b>3.03 - Youth Room Assignment</b></p>			<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 3.03</b></p>	<p><b>YES</b></p>		
	<p>If NO, explain here:</p>		
	<p>The agency has the required policy and procedures 3.03 - Youth Room and Bed Assignment - Youth Safety that was approved 10/31/2024 by the Program Director.</p>		
<p><b>A process is in place that includes an initial classification of the youths, to include:</b></p>			
<p>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</p>	<p><b>Compliance</b></p>	<p>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.</p>	

<p>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</p>	<p><b>Compliance</b></p>	<p>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.</p>	
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>			
<p><b>3.04 - Log Books</b></p>			<p><b>Limited</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 3.04</b></p>	<p><b>YES</b></p>		
	<p>If NO, explain here:</p>		
	<p>The agency has the required policy and procedures 3.04 Log Books (Manual and Electronic), that was approved 11/12/2024 by the Program Director.</p>		
<p>Log book entries that could impact the security and safety of the youth and/or program are highlighted</p>	<p><b>Compliance</b></p>	<p>Review of the electronic logbook entries showed entries that impact the security and safety of the youth and/or program were highlighted and/or was depicted in a different color font.</p>	
<p>All entries are brief, legibly written in ink and include:  <ul style="list-style-type: none"> <li>• Date and time of the incident, event or activity</li> <li>• Names of youth and staff involved</li> <li>• Brief statement providing pertinent information</li> <li>• Name and signature of person making the entry</li> </ul> </p>	<p><b>Compliance</b></p>	<p>All logbook entries reviewed from September 2024 - February 2025 were accurately recorded, including dates, names, times, assigned staff, and youth, ensuring comprehensive documentation.</p>	
<p>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.</p>	<p><b>Compliance</b></p>	<p>All entries were typed using an electronic system logbook, and any errors made were documented and corrected.</p>	
<p>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</p>	<p><b>Exception</b></p>	<p>Reviews of the electronic logbook was conducted to determine if the program director or designee reviewed the entries on a regular basis (minimum of once every week) and made notes indicating the dates reviewed and provided corrections, recommendations and/or follow-ups where needed with a signed/dated entry.</p>	<p>From September to November 2024, there were no entries from the Shelter Manager. Entries began on December 11th but lacked consistency. For example, the gap between December 12th and December 26th is 14 days. In January 2025, there was a gap between entries from January 2nd to January 13th (11 days). Overall, the entries for weekly reviews of the logbook failed to be conducted consistently.</p>

<p>All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed</p>	<p><b>Compliance</b></p>	<p>Logbook entries reviewed from September to February consistently showed proper documentation of staff reviews from the previous two shifts. Each entry included the required signatures and dates, confirming that the reviews were conducted in accordance with established procedures</p>	
<p>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.</p>	<p><b>Exception</b></p>	<p>The logbook entries reviewed from September to February indicated that a supervisor consistently reviewed the logbook at the beginning of their shift, with the exception of weekends.</p>	<p>There is no recorded entry for the counselor reviews of the logbook, as entries did not begin until November 2024. Additionally, the dates for the reviewed entries are missing from the notes.</p>
<p>Logbook entries include: a. Supervision and resident counts b. Visitation and home visits</p>	<p><b>Compliance</b></p>	<p>The logbook entries reviewed indicated that home visits and supervision counts were consistently documented. Each entry reflected detailed records of the activities conducted, ensuring accurate tracking of home visits and supervision sessions as part of the ongoing oversight and management process. This documentation supports accountability and adherence to procedural standards.</p>	
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			
<p><b>3.05 - Behavior Management Strategies</b></p>			<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 3.05</b></p>	<p><b>YES</b></p>		
	<p>If NO, explain here:</p>		
	<p>The agency has the required policy and procedures 3.05 Behavior Management Strategies and Intervention that was approved 10/31/2024 by the Program Director.</p>		
<p>The program has a detailed written description of the BMS and it is explained during program orientation</p>	<p><b>Compliance</b></p>	<p>The daily programming schedule is included in both the youth handbook and a separate Journey to Success Guide, ensuring that youth have access to a clear outline of their activities.</p>	
<p><b>Behavior Management Strategies must include:</b></p>			

<p>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</p>	<p><b>Compliance</b></p>	<p>"Journey to Success" is a weekly point-based system and rewards program designed to foster and reinforce positive behaviors. Youth earn points ranging from 0 to 804, with their daily behavior tracked throughout the week. At the week's end, their points log is reviewed by the YCW to address any behavioral concerns. Youth can exchange points for rewards such as candy, snacks, personal items, or electronics. The BMS is structured to promote safety, fairness, and positive behavior reinforcement through incentives and appropriate consequences. Disciplinary measures are designed to maintain the youth's basic rights without restriction.</p>	
<p><b>Program's use of the BMS</b></p>			
<p>All staff are trained in the theory and practice of administering BMS rewards and consequences</p>	<p><b>Compliance</b></p>	<p>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.</p>	
<p>There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences</p>	<p><b>Compliance</b></p>	<p>Feedback is provided to staff daily or during employee of the month. The shelter manager consistently commends the staff for a job well done.</p>	
<p>Supervisors are trained to monitor the use of rewards and consequences by their staff</p>	<p><b>Compliance</b></p>	<p>Training documentation showed all supervisory staff are trained in the BMS and to monitor the use of rewards and consequences by their staff.</p>	
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>			
<p><b>3.06 - Staffing and Youth Supervision</b></p>			<p><b>Limited</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 3.06</b></p>	<p><b>YES</b></p>		
	<p>If NO, explain here:</p>		
	<p>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 10/31/2024.</p>		

<p>The program maintains minimum staffing ratios as required by Florida Administrative Code and contract.</p> <ul style="list-style-type: none"> <li>• 1 staff to 6 youth during awake hours and community activities</li> <li>• 1 staff to 12 youth during the sleep period</li> </ul>	<p><b>Compliance</b></p>	<p>The schedules reviewed from September to February consistently show that a minimum of two staff members were assigned to each shift. This staffing structure ensures adequate coverage and supervision, supporting the overall safety and well-being of the youth in the program.</p>	
<p>All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements</p>	<p><b>Compliance</b></p>	<p>The schedules reviewed from September 2024 to February 2025 consistently showed a minimum of two shelter staff members assigned to each shift. The shifts were scheduled as follows: 6:30 AM to 3:30 PM, 2:30 PM to 11:00 PM, and 10:30 PM to 7:00 AM. One schedule was missing for the period from November 24, 2024, to November 30, 2024, but the shelter staff provided a copy upon request. Additionally, between 3 to 5 shelter staff members were scheduled per shift, including the presence of a shelter supervisor starting in November 2024.</p>	
<p>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</p>	<p><b>Compliance</b></p>	<p>All new staff hired were background screened and properly trained youth care workers. A review of eligible re-screened staff indicate continued eligible screening results for the applicable staff.</p>	
<p>The staff schedule is provided to staff or posted in a place visible to staff</p>	<p><b>Compliance</b></p>	<p>A staff schedule is posted in the office for easy reference</p>	
<p>There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed</p>	<p><b>Compliance</b></p>	<p>There is a staff rotation posted in staff office. In the event either of the two staff is not available then the staff working during that shift are asked to remain to cover the shift.</p>	

<p>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</p>	<p><b>Exception</b></p>	<p>Bed checks were reviewed for the following dates and times: February 12th from 2:00 AM to 4:00 AM, February 16th from 4:00 AM to 6:00 AM, and March 1st from 12:00 AM to 2:00 AM.</p>	<p>On the boys' dorm, bed checks were documented in the logbook at 2:00 AM and 2:15 AM; however, these checks were not observed on camera. Additional entries indicating completed bed checks at 2:30 AM, 2:45 AM, and 3:00 AM were also not visible on the video footage. The video recording skips from 3:00 AM to 3:23 AM, while the logbook notes a bed check at 3:15 AM. Another video gap occurs from 3:23 AM to 3:51 AM, during which a 3:30 AM bed check is recorded in the logbook. These discrepancies suggest a lack of alignment between the documented checks and the available video footage. Per observation of the finding, the provider was advised to report the incidents to CCC. The report was accepted by CCC.</p>
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			
<p><b>3.07 - Video Surveillance System</b></p>			<p><b>Limited</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 3.07</b></p>	<p><b>YES</b> If NO, explain here: The agency has the required policy and procedures 3.08 - Video Surveillance System, that was approved 11/12/2024 by the Program Director.</p>		
<p><b>Surveillance System</b></p>			
<p>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</p>	<p><b>Compliance</b></p>	<p>The agency is in compliance with all requirements. A written security notice is clearly posted on the premises. The surveillance system captures and retains video footage for a minimum of 30 days, records date, time, and location, and maintains resolution suitable for facial recognition. The system includes backup capabilities to operate during power outages. Cameras are appropriately placed in designated interior and exterior areas where youth, staff, and visitors congregate, including locations where youth searches are conducted. No cameras are placed in bathrooms or sleeping quarters, and all cameras are visible.</p>	

<p>A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?</p>	<p><b>Compliance</b></p>	<p>A list of designated administrators with access to the video surveillance system is maintained in the intake staff office.</p>	
<p>Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.</p>	<p><b>Exception</b></p>	<p>Camera review entries documented in the logbook from September 2024 to the current date show dates of reviews.</p>	<p>Supervisory camera review entries documented in the logbook from September 2024 did not document the timeframes reviewed. One entry noted a camera review from 1/25/25 to 1/28/25 without specifying the times. The reviews occur approximately every three weeks to one month, with the following recorded dates: 09/01/24, 10/04/24, 11/15/24, 12/02/24, 12/11/24, 12/20/24, 12/28/24, 01/02/25, 01/10/25, 01/24/25, 01/28/25, 02/11/25, 02/15/25, 02/18/25, and 02/26/25.</p>
<p>The reviews assess the activities of the facility and include a review of random sample of overnight shifts</p>	<p><b>Exception</b></p>	<p>Supervisory reviews of the video system and corresponding documentation are logged in the logbook. A review of the logbook entries from September 2024 to the current date was conducted.</p>	<p>The camera review entries in the logbook from September 2024 to the current date document the dates of reviews, but the specific times were not recorded. For instance, one entry covering the period from 01/25/25 to 01/28/25 indicated the review but did not include times. Reviews were conducted approximately every three weeks to one month, with the following dates documented: 09/01/24, 10/04/24, 11/15/24, 12/02/24, 12/11/24 (two entries), 12/20/24, 12/28/24, 01/02/25, 01/10/25, 01/24/25, 01/28/25 (two entries), 02/11/25, 02/15/25, 02/18/25, and 02/26/25.</p>
<p>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</p>	<p><b>Compliance</b></p>	<p>The agency uses the Alibi system to grant requests for video recordings, ensuring that results are provided within 24 to 72 hours following program quality improvement visits or when an investigation is initiated after an allegation of an incident.</p>	
<p>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</p>	<p><b>No eligible items for review</b></p>	<p>No documentation was provided indicating that any cameras required repairs within the last six months.</p>	

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

**Standard Four – Mental Health/Health Services**

<b>4.01 - Healthcare Admission Screening</b>		<b>Satisfactory</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 4.01</b>	<b>YES</b>		
	If NO, explain here:		
	The agency has the required policy and procedures titled 4.01 Healthcare Admission Screening (Physical Health Screening) that was approved 11/12/2024 by the Program Director.		
<b>Preliminary Healthcare Screening</b>			
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	<b>Compliance</b>	The program has written policy and procedures to ensure all youth are provided a physical health screening upon admission into the shelter. In addition, the policy requires the program to complete referrals and follow-ups as needed. Five youth records were reviewed and each record included healthcare screenings with all required elements.	
<b>Referral and Follow-Up</b>			
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.)	<b>No eligible items for review</b>	Five youth records were reviewed and none of the youth were in need of a referral for medical care.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	<b>Compliance</b>	One of the five youths was applicable for parent involvement with coordinating and scheduling of follow-up medical appointments. An informal interview with the registered nurse in comparison with documentation confirmed the parent handles all scheduling of appointments.	
All medical referrals are documented on a daily log.	<b>No eligible items for review</b>	None of the reviewed records were referred for medical care.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	<b>Compliance</b>	The program has written policy and procedures to ensure all youth are provided a physical health screening upon admission into the shelter. The program's practice includes a thorough referral process and mechanism for necessary follow-up medical care as required and/or needed.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			

<b>4.02 - Suicide Prevention</b>		<b>Limited</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 4.02</b>	<b>YES</b>		
	If NO, explain here:		
	The agency has the required policy and procedures titled 4.02 Suicide Prevention, that was approved 11/12/2024 by the Program Director.		
<b>Suicide Risk Screening and Approval (<i>Residential and Community Counseling</i>)</b>			
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.	<b>Compliance</b>	The program has a written policy and procedures which ensures all youth are screened for mental health and substance abuse at the time of intake. When suicide risk is indicated as a result of suicide risk screening, a licensed mental health staff will assess the youth within 24 hours. A review of six youth records found each youth had an initial suicide screening during the intake process signed by a supervisor.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	<b>Compliance</b>	The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services.	
<b>Supervision of Youth with Suicide Risk (<i>Shelter Only</i>)</b>			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	<b>Compliance</b>	A review of three residential youth records found each youth was placed on the appropriate level of supervision based on the results of the assessment.	

<p>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</p>	<p><b>Exception</b></p>	<p>The three youth placed on sight and sound observation required documented observations of the youth's behavior at thirty minute or less intervals.</p>	<p>Three youth records were reviewed and found each record's observation of the youth's behavior was not documented in accordance to policy. Each youth's observation times, documented in the Note Active electronic logbook, were completed late on various dates. One youth's observation log reflected times on 12/20/2024 at 7:47pm then 9:45pm; 12/21/2024, at 2:29pm then 3:03pm, 4:57pm then 5:49pm, and 8:48pm then 10:36pm; 12/22/2024, at 6:45am then 8:00am, 8:46am then 9:31am, 9:31am then 10:28am, 10:28am then 11:01am, 1:21pm then 1:52pm; and on 12/23/2024, at 7:15am then 9:47am, 10:01am then 11:34am, 1:15pm then 1:51pm. Another youth's log documented on 2/28/2025, at 1:44am then 3:17am, 2:31pm then 3:06pm, 5:00pm then 5:34pm, and 3/2/2025, at 3:44pm then 4:17pm, 7:10pm then 7:45pm. The third youth's log reflected on 9/19/2024, at 5:44am then 6:17am, 6:17am then 7:56am, 10:00am then 11:30am; 9/20/2024, at 5:59pm then 6:05pm; on 9/21/2024, at 2:49pm then 4:25pm, 5:00pm then 5:36pm, and 6:15pm then 6:59pm; on 9/22/2024, at 7:59pm then 8:34pm, 8:34pm then 9:59pm; and on 9/23/24, at 8:47am then 9:23am.</p>
<p>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.</p>	<p><b>Compliance</b></p>	<p>The program documents youth behavior in a electronic log book. A review of the logbook confirmed the time of day, the behavior observed, warnings, and the staff's name entering the entry.</p>	
<p>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</p>	<p><b>Compliance</b></p>	<p>Reviewed documentation confirmed all three youth's levels were not reduced/changed until a licensed professional completed a further assessment or Baker Act by law enforcement.</p>	
<p>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.</p>	<p><b>Compliance</b></p>	<p>The program uses an electronic log which is reviewed by a supervisor on each shift.</p>	
<p><b>Youth with Suicide Risk (Community Counseling Only)</b></p>			

<p>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.</p>	<p><b>Compliance</b></p>	<p>Three community counseling youth records were reviewed. Each youth was assessed by a licensed professional. The parent was on-site at the time of the assessment and the supervisor was made aware of the results.</p>	
<p>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.</p>	<p><b>Compliance</b></p>	<p>Each youth's record included documentation to confirm a licensed mental health staff completed the assessment.</p>	
<p>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.</p>	<p><b>Compliance</b></p>	<p>Each youth's record included documentation to reflect the parent was provided with the results and provided a providers list in the event of an emergency.</p>	
<p>If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.</p>	<p><b>No eligible items for review</b></p>	<p>The parents were present for all three records reviewed.</p>	
<p>When the screening was completed during school hours on school property, the appropriate school authorities were notified.</p>	<p><b>No eligible items for review</b></p>	<p>None of the reviewed records were screened during school hours/on school property.</p>	
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>			
<p><b>4.03 - Medications</b></p>			<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 4.03</b></p>	<p><b>NO</b></p>		
	<p>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.</p>		
	<p>The agency has a policy and procedures titled 4.03 Medications (Storage, Access, Inventory, Administration, Documentation and Disposal), that was approved 7/1/2024 by the Program Director.</p>		
<p>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.</p>	<p><b>Compliance</b></p>	<p>The program has one registered nurse (RN) and documentation showed the RN credentials have been verified and valid.</p>	

<p>The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication:</p> <ul style="list-style-type: none"> <li>a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse</li> <li>b. Evidence demonstrating their competency to assist with self-administration of medication distribution</li> <li>c. Maintenance of their annual medication training re-certification</li> </ul>	<p><b>Compliance</b></p>	<p>A review of staff training records in comparison with an informal interview with the nurse confirm all staff are trained in medication administration. The program also has a list of designated staff authorized to provide medication.</p>	
<p>The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess:</p> <ul style="list-style-type: none"> <li>a. strategies implemented to reduce medication errors shelter wide</li> <li>b. analyze factors that contributed to medication errors</li> <li>c. allow staff the opportunity to practice and role-play solutions</li> </ul>	<p><b>Compliance</b></p>	<p>A review of the program's monthly meeting agenda validated the nurse conducts meetings to address medication errors and other factors relating to medication.</p>	
<p>The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.</p>	<p><b>Compliance</b></p>	<p>The program's practice is to set alarms on the phone, tablets, verbal reminders, and the medication time chart to ensure medication is provided within the required timeframe.</p>	
<p>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</p>	<p><b>Compliance</b></p>	<p>The program has a weekly calendar which has designated staff assigned to administer medication daily.</p>	
<p>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.</p>	<p><b>Compliance</b></p>	<p>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.</p>	
<p>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:</p> <ul style="list-style-type: none"> <li>a. to ensure appropriate medication management and distribution methods</li> <li>b. to track medication errors</li> <li>c. to identify systemic issues and implement mitigation strategies, as appropriate.</li> </ul>	<p><b>Compliance</b></p>	<p>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.</p>	
<p><b>Admission/Intake of Youth</b></p>			

<p>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. <i>*If the agency does not have an RN, there was a medication review conducted by an LPN or certified Leadership position.</i></p> <p>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.</p>	<p><b>Compliance</b></p>	<p>A review of three youth records confirmed during admission the youth and parent were interviewed about current medication within the required timeframe by the required staff. Documentation supported the registered nurse reviewed all medical information recorded by staff within three business days if not present during admission.</p>	
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**Medication Storage**

<p>a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff)</p> <p>b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management</p> <p>c. Oral medications are stored separately from injectable epi-pen and topical medications</p> <p>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.)</p> <p>e. Narcotics and controlled medications are stored in the Pyxis ES Station</p> <p>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</p>	<p><b>Compliance</b></p>	<p>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.</p>	
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**Medication Distribution**

<p>a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station</p> <p>b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics)</p> <p>c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff</p> <p>d. Agency verifies medication using one of three methods listed in the FNYFS Policies &amp; Procedures Manual</p> <p>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.</p> <p>f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens</p> <p>h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse</p>	<p><b>Compliance</b></p>	<p>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.</p>	
<p>The medication distribution log documentation includes:</p> <p>a. the time of medication administration</p> <p>b. evidence of youth initials that the dosage was given</p> <p>c. evidence of staff initials that the dosage was given</p>	<p><b>Compliance</b></p>	<p>A review of three youth medication distribution log documented each youth's time of medication, youth initials, and staff initials who gave the dosage.</p>	
<p>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.</p>	<p><b>Compliance</b></p>	<p>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.</p>	
<p>During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.</p>	<p><b>Compliance</b></p>	<p>There were no reported instances of a youth missing medication due to failure of the Pyxis machine.</p>	

<p><b>If applicable:</b> 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 <b>in-person</b> medication administration training, demonstrating competency and re-certification from an RN.</p>	<p><b>Compliance</b></p>	<p>The program had two instances where two staff were responsible for medication error. On November 21, 2024, one staff had a medication error and was retrained on the following day by the nurse November 22, 2025. On March 1, 2025 another staff had a medication error. Training is currently pending for the staff. The staff is currently not on the schedule.</p>	
<p><b>Medication Inventory</b></p>			
<p>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</p>	<p><b>Compliance</b></p>	<p>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.</p>	
<p>There are monthly reviews of the Pyxis reports to monitor medication management practice.</p>	<p><b>Compliance</b></p>	<p>Reviewed documentation confirmed monthly reviews of the Pyxis reports were maintained since the last review period.</p>	
<p>Medication discrepancies are cleared after each shift.</p>	<p><b>Compliance</b></p>	<p>Reviewed documentation as well as an interview with the nurse confirmed medication discrepancies are cleared after each shift.</p>	
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>			

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 11/12/2024 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.
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	Compliance	A review of staff training records in comparison with an informal interview with the nurse confirm all staff are trained in emergency care for medical and mental health concerns.
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 maintains an alert form in each youth's record which has color coded dots to identify youth with health or mental health concerns when applicable. The program also uses an alert board, which can be found in the intake office with color coded dots which match the alert form for the applicable youth. Each of the five residential youth record demonstrated alerts were documented in the files and communicated to staff.
<b>Additional Comments:</b> There are no additional comments for this indicator.		

<b>4.05 - Episodic/Emergency Care</b>		<b>Satisfactory</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 4.05</b>	<b>YES</b>		
	If NO, explain here:		
	The agency has the required policy and procedures 4.05 - Episodic/Emergency Care, that was approved 11/12/2024 by the Program Director.		
<b>Off Site Emergency Care</b>			
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	<b>Compliance</b>	The program has written policy and procedures to ensure the provision of emergency medical and dental care. The procedures list all required elements. A review of three youth records found each youth required off-site medical care. Each youth returned with discharge instructions. All three youth were documented in the electronic log. Each youth's record documented parent notification.	
All staff are trained on emergency medical procedures	<b>Compliance</b>	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)	<b>Compliance</b>	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.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			