



**Florida Network for Youth and Family Services
Compliance Monitoring Report for FY 2025-2026**

ARNETTE HOUSE

2310 NE 24th Street
Ocala, FL 34470

January 28-29, 2026

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 Arnette House for the FY 2025-2026 at its program office located at 2310 NE 24th Street Ocala, Florida 34470. 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. Arnette House 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 2025 through June 30, 2026.

The compliance monitoring review was conducted by Keith Carr, Consultant for Forefront LLC. Agency representatives from Arnette House present for the entrance interview were Cheri Pettitt, Chief Executive Officer, Mark Shearon, Chief Operations Officer, Jason Kasten, Chief Financial Officer, Shanda Hope, Clinical Supervisor, Pam Washington, Residential Supervisor and several additional staff in administration and programs. The last onsite QI program review visit was conducted on October 23-24, 2024.

In general, the Reviewer found that Arnette House is in compliance with specific contract requirements. **ARNETTE HOUSE received an overall compliance rating of 100% for achieving full compliance with 13 applicable indicators** out of a total of 15 indicators on the CINS/FINS Monitoring Tool. There were no 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

2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 1-28-29-2026

Agency Name: Arnette House					Monitor Name: Keith Carr, Lead Reviewer		
Contract Type : CINS/FINS					Region/Office: 2310 NE 24th Street Ocala, Florida 34470		
Service Description: Comprehensive Onsite Compliance Monitoring					Site Visit Date(s): January 28-29, 2026		
Major Programmatic Requirements	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable:
	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable		
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D, I: The agency has a total of three certified DJJ QI Peer reviewers. These reviewers include Mark Shearon, Pamela Washington, and Shand Hope.	No recommendation or corrective action.
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: The provider receives grant funds from various funding sources including United Way, Federal Basic Center, Department of Children and Families, and Sexauer Foundation.	No recommendation or corrective action.
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of \$100,000 per accident, \$100,000 per person and \$500,000 policy aggregate. Commercial General Liability with a limit of \$500,000 per occurrence, and \$1,000,000 policy aggregate. Automobile Liability Insurance shall be	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: agency provided a certificate of insurance produced by Brown and Brown of Florida, Inc. with the following insurers affording coverage: Philadelphia Indemnity Insurance Company and Associated Industries Insurance Company, Inc. The coverages are effective from 12/01/2024-12/01/2026 for the following coverages and limits.	No recommendation or corrective action.

2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 1-28-29-2026

Agency Name: Arnette House					Monitor Name: Keith Carr, Lead Reviewer		
Contract Type : CINS/FINS					Region/Office: 2310 NE 24th Street Ocala, Florida 34470		
Service Description: Comprehensive Onsite Compliance Monitoring					Site Visit Date(s): January 28-29, 2026		
	Explain Rating						
Major Programmatic Requirements	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable:
required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of \$250,000 per person; with a minimum limit for bodily injury of \$500,000 per accident; with a minimum limit for property damage of \$100,000 per accident and with a minimum limit for medical payments or \$5,000-\$10,000 per person. Florida Network is listed as payee or co-payee. PTV						Commercial General Liability; \$1,000,000 each occurrence, \$1,000,000 damage to rented premises, \$20,000 medical expense, \$1,000,000 personal injury, \$3,000,000 general aggregate and product aggregate; Automobile Liability with a combined single limit of \$1,000,000; umbrella liability with a \$1,000,000 limit per occurrence and \$1,000,000 aggregate. The worker's Compensation and employee liability for each \$1,000,000, \$1,000,000 employee and \$1,000,000 policy limit that is effective 02/28/2026 and 02/28/2026. The certificate lists The Florida Network of Youth and Families as a certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	I: The agency reported that there are no corrective action items (fiscal or non-fiscal) cited by other external funders	Not applicable.
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency has employee and fiscal policies and procedures that are in compliance with generally accepted accounting principles (GAAP) and	No recommendation or corrective action.

2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 1-28-29-2026

Agency Name: Arnette House					Monitor Name: Keith Carr, Lead Reviewer		
Contract Type : CINS/FINS					Region/Office: 2310 NE 24th Street Ocala, Florida 34470		
Service Description: Comprehensive Onsite Compliance Monitoring					Site Visit Date(s): January 28-29, 2026		
Major Programmatic Requirements	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable:
	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable		
GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. PTV						provide sound internal controls. At the time of the program review, the agency maintains fiscal files which are audit ready.	
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: The agency's general ledger from July 1, 2025 to December 1, 2025 was reviewed. The general ledger tracks all financial activities of this grant separately from other funding sources with the use of standard entity account numbers.	No recommendation or corrective action.
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) -ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: Petty cash is maintained by the administrative assistant. It is kept in a locked box in the front office. The petty cash limit is \$200. The petty cash is used to cover small, unexpected expenses that may not require a check. Receipts for funds received from petty cash are submitted to the administrative assistant. The administrative assistant reconciles all receipts and cash on hand and submits requests to the finance department for reimbursement to the petty cash fund. Petty cash was verified while on-site during the	No recommendation or corrective action.

2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 1-28-29-2026

Agency Name: Arnette House					Monitor Name: Keith Carr, Lead Reviewer		
Contract Type : CINS/FINS					Region/Office: 2310 NE 24th Street Ocala, Florida 34470		
Service Description: Comprehensive Onsite Compliance Monitoring					Site Visit Date(s): January 28-29, 2026		
Major Programmatic Requirements	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable:
	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable		
						program review and all funds were accurately reconciled.	
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). ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: The agency provided current financial reports for the past six months, July 2024- December 2025. First federal Bank document July 2025 through December 2025 bank statements reviewed and included reconciliation reports. Bank statements are reconciled by the director of finance and reviewed by the CEO or Board Treasurer. Bank statements for the most recent six months all demonstrate proof of reconciliation within days of the end of the previous month. Invoices are reconciled by the finance department, prepared for payment, and approved by the CEO. Invoices are paid as required.	No recommendation or corrective action.
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over \$1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. PTV/ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	D: The agency does not have an inventory, including computers over \$1000 requiring a DJJ property inventory number/ tag.	Not Applicable.

2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 1-28-29-2026

Agency Name: Arnette House					Monitor Name: Keith Carr, Lead Reviewer		
Contract Type : CINS/FINS					Region/Office: 2310 NE 24th Street Ocala, Florida 34470		
Service Description: Comprehensive Onsite Compliance Monitoring					Site Visit Date(s): January 28-29, 2026		
	Explain Rating						
Major Programmatic Requirements						Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable:
	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable		
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. ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: The agency provided their two most recent quarterly tax reports for the 2025 calendar year covering months including April, May, June, July, August, September with proof of corresponding payment. The agency's quarterly tax payment reports and payments are managed by ADP, a third party payroll company. Employee IRS W-2 and 1099 forms are all produced and managed by ADP.	No recommendation or corrective action.
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. PTV/ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: Information provided by the director of finance. The documents provided included Budget to Actuals FY 2026 covering July 2025-December 2025. The agency continues to hold quarterly finance meetings with the director of finance, CEO, finance assistant, board chair, secretary, and vice-president. The agency's profit and loss, budget versus actual, and variances for fiscal year 2025-2026 are reviewed quarterly.	No recommendation or corrective action.
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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: The agency has financial statements and an independent auditor's report dated June 30, 2024,	No recommendation or corrective action.

2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 1-28-29-2026

Agency Name: Arnette House					Monitor Name: Keith Carr, Lead Reviewer		
Contract Type : CINS/FINS					Region/Office: 2310 NE 24th Street Ocala, Florida 34470		
Service Description: Comprehensive Onsite Compliance Monitoring					Site Visit Date(s): January 28-29, 2026		
	Explain Rating						
Major Programmatic Requirements						Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable:
	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable		
management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. Can obtain from FNYFS						prepared by Purvis Gray certified public accountants. There are no findings stated within the official audit report. A copy of the audit report has been submitted to the Florida Network of Youth and Family Services.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: The agency has policies and procedures to ensure the security and privacy of all employees and client data is maintained. Personal information is not easily accessible, and the agency maintains a backup system in case of accidental loss of financial information. There are security procedures in place to protect laptops. Documents and computer hard drives are properly.	No recommendation or corrective action.
j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least \$19.00 per hour. This also includes funding for additional staff as approved by the Department. ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: The agency provided payroll checks for every employee confirming they earn at least \$19.00 per hour.	No recommendation or corrective action.

2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 1-28-29-2026

Agency Name: Arnette House					Monitor Name: Keith Carr, Lead Reviewer		
Contract Type : CINS/FINS					Region/Office: 2310 NE 24th Street Ocala, Florida 34470		
Service Description: Comprehensive Onsite Compliance Monitoring					Site Visit Date(s): January 28-29, 2026		
	Explain Rating						
Major Programmatic Requirements	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable:
Disaster Planning k. The agency has a written policy and procedure that includes a policy title/number, date of last review/revision, meets all of the requirements for the indicator that has been approved. The agency has a comprehensive Disaster Preparedness Plan that includes the following: <ul style="list-style-type: none"> o Emergency evacuation protocols o Severe weather procedures o Evacuation logistics (shelter only) o Evacuation facility designation (shelter only) o Critical Resource Planning o Florida Network and DJJ notification requirements The Universal Agreement/Emergency Disaster Shelter document is signed by the agency executive. The comprehensive Disaster Preparedness Plan is submitted to the Florida Network annually, no later than February 1st. ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: Documentation: The provider maintains an Emergency Disaster Plan that includes a procedural guide in emergency situations. The most recent annual review of the plan was conducted in February 2026. The Disaster Preparedness Plan includes all required elements. The Universal Agreement/Emergency Disaster Shelter document was signed by the agency executive.	

2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 1-28-29-2026

CONCLUSION

Arnette House has met the requirements for the CINS/FINS contract as a result of full compliance with twelve applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the 15 compliance monitoring indicators were not applicable because the agency has no corrective action items cited by external funding sources and maintains no inventory of items valued over \$1000 purchased with funds from the Florida Network of Youth and Family Services. Consequently, the overall compliance rate for this contract monitoring visit is 100%. There are no corrective actions cited. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings..

SUMMARY OF CORRECTIVE ACTIONS or RECOMMENDATIONS

None.

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



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Arnette House
CINS/FINS Program
2310 NE 24th Street Ocala, FL 34470
January 28-29, 2026

Compliance Monitoring Services Provided by



CINS/FINS Rating Profile

Domain 1: Background Screening and Compliance

1.0 Background Screening of Employees/Volunteers	Satisfactory with Exception(s)
1.1 Annual Affidavit of Compliance with Good Moral Character Standards	Satisfactory
1.2 Provision of an Abuse Free Environment	Satisfactory
1.3 Incident Reporting	Satisfactory
1.4 Training Requirements	Satisfactory with Exception(s)
1.5 Data Entry & Collection	Satisfactory
1.6 Analyzing and Reporting	Satisfactory with Exception(s)
1.7 Client Transportation	Satisfactory with Exception(s)
1.8 Client Contact	Satisfactory
1.9 Outreach Services	Satisfactory with Exception(s)

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

Domain 3: Screening, Assessment & Case Management

3.2 Admission Process	Satisfactory
3.3 NIRVANA (Network Inventory of Risks, Victories, and Needs Assessment)	Satisfactory with Exception(s)
3.4 Case Management, Counseling & Non-Residential Services Policy	Satisfactory with Exception(s)
3.5 Adjudication Services: Case Staffing	Satisfactory
3.6 Adjudication Services: CINS Petition Process	Satisfactory
3.7 Service Plan	Satisfactory with Exception(s)
3.8 Youth Records	Satisfactory
3.10 Discharge and Follow Up	Satisfactory with Exception(s)

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

Domain 4: SNAP ® Programs

4.0 SNAP® Under 12	Satisfactory
4.1 SNAP® Fidelity Monitoring	Satisfactory
4.2 SNAP® for Youth	Not Applicable
4.3 SNAP® Youth Justice	Satisfactory
4.5 SNAP® for Schools and Communities	Satisfactory

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

Domain 5: Shelter Program Services

5.0 Shelter Program Services	Satisfactory
5.1 Shelter Environment	Satisfactory with Exception(s)
5.2 Shelter Search Policy	Satisfactory with Exception(s)
5.3 Logbook Requirements	Limited
5.4 Staffing Standards and Enhanced Supervision	Satisfactory
5.5 Behavior Management Strategies	Satisfactory
5.6 Program Orientation	Satisfactory
5.7 Youth Room Assignment	Satisfactory
5.8 Video Surveillance	Satisfactory

Percent of indicators rated Satisfactory: 88.89 %
Percent of indicators rated Limited: 11.11 %
Percent of indicators rated Failed: 0 %

Domain 6: Medication Management

6.0 Medication Management and Distribution	Satisfactory
6.1 Naloxone Administration and Opioid Overdose Response	Satisfactory
6.2 Suicide Prevention	Satisfactory with Exception(s)
6.3 Healthcare admission Screening	Satisfactory
6.4 Medical/Mental Health Alert Process	Satisfactory

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 97.22 %
Percent of indicators rated Limited: 2.78 %
Percent of indicators rated Failed: 0 %

Rating Definitions

Ratings were assigned to each indicator by the review team using the following definitions:

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.
Not Applicable	Does not apply.

Reviewers

Members

- Keith Carr - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
- Patrick Mckinstry – Regional Monitor, Department of Juvenile Justice
- Venus Highsmith – Regional Director, NEED
- Carrie Connell – LCSW, Clinical Director, CCYS
- Camille Haynes – Residential Supervisor, Orange County Government
- Devonte Johnson – Residential Supervisor, INA, Boystown of Central Florida

Methodology

This review was conducted in accordance with FDJJ-2000 (Quality Assurance Policy and Procedures), and focused on the areas of Domain (1) - Domain (6), which are included in the Children/Families in Need of Services (CINS/FINS) Standards (Effective July 1, 2025).

Persons Interviewed

- Chief Executive Officer
- Chief Financial Officer
- Chief Operating Officer
- Executive Director
- Program Director
- Program Manager
- Program Coordinator
- Clinical Director
- Counselor Licensed

- Case Manager
- Counselor Non-Licensed
- Advocate
- Direct – Care Full time
- Direct – Part time
- Direct – Care On-Call
- Intern
- Volunteer
- Human Resources

- Nurse – Full time
- Nurse – Part time
- 2 # Case Managers
- 1 # Program Supervisors
- # Food Service Personnel
- 1 # Healthcare Staff
- 1 # Maintenance Personnel
- # Other (listed by title): ___

Documents Reviewed

- Accreditation Reports
- Affidavit of Good Moral Character
- CCC Reports
- Logbooks
- Continuity of Operation Plan
- Contract Monitoring Reports
- Contract Scope of Services
- Egress Plans
- Fire Inspection Report
- Exposure Control Plan

- Table of Organization
- Fire Prevention Plan
- Grievance Process/Records
- Key Control Log
- Fire Drill Log
- Medical and Mental Health Alerts
- Precautionary Observation Logs
- Program Schedules
- List of Supplemental Contracts
- Vehicle Inspection Reports

- Visitation Logs
- Youth Handbook
- 8 # Health Records
- 10 # MH/SA Records
- 11 # Personnel /Volunteer Records
- 9 # Training Records
- 5 # Youth Records (Closed)
- 5 # Youth Records (Open)
- 6 # Other: Medication (4) Suicide (4)
- ___

Observations During Review

- Intake
- Program Activities
- Recreation
- Searches
- Security Video Tapes
- Social Skill Modeling by Staff
- Medication Administration

- Posting of Abuse Hotline
- Tool Inventory and Storage
- Toxic Item Inventory & Storage
- Discharge
- Treatment Team Meetings
- Youth Movement and Counts
- Staff Interactions with Youth

- Staff Supervision of Youth
- Facility and Grounds
- First Aid Kit(s)
- Group
- Meals
- Signage that all youth welcome
- Census Board

Surveys

7 # of Youth

12 # of Direct Staff

of Other

Comments

A Quality Improvement Program Review was conducted for FY 2025-2026

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

Arnette House, Inc. is a not-for-profit corporation organized under the laws of the state of Florida on April 22, 1981. Arnette House primarily provides residential services to youth adolescents between the ages of 10 and 17 and non-residential services to youth 6 and 17, in Marion and Lake counties, who are runaways or are experiencing a family crisis, until adequate disposition is made for the youth. The programs offered by Arnette House include: shelter services, community counseling services, and Stop Now and Plan (SNAP). The agency reported no major or critical staffing, operations and programming issues.

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

Domain 1: There are nine indicators for Domain 1.

Indicator 1.0 Background Screening of Employees/Volunteers was rated Satisfactory with Exception(s)

Indicator 1.1 Annual Affidavit of Compliance with Good Moral Character Standards was Satisfactory

Indicator 1.2 Provision of an Abuse Free Environment was rated Satisfactory

Indicator 1.3 Incident Reporting was rated Satisfactory

Indicator 1.4 Training Requirements was rated Satisfactory with Exception(s)

Indicator 1.5 Data Entry & Collection was rated Satisfactory

Indicator 1.6 Risk Management/ Analyzing and Reporting Information was rated Satisfactory with Exception(s)

Indicator 1.7 Client Transportation was rated Satisfactory with Exception(s)

Indicator 1.8 Client Contact was rated Satisfactory

Indicator 1.9 Outreach Services was rated Satisfactory with Exception(s)

Domain 3: There are eight indicators for Domain 3.

Indicator 3.2 Admission Process was rated Satisfactory

Indicator 3.3 NIRVANA (Network Inventory of Risks, Victories, and Needs Assessment) was rated Satisfactory with Exception(s)

Indicator 3.4 Case Management, Counseling & Non-Residential Services Policy was rated Satisfactory with

Indicator 3.5 Adjudication Services: Case Staffing was rated Satisfactory

Indicator 3.6 Staffing and Youth Supervision was rated Satisfactory

Indicator 3.7 Service Plan was rated Satisfactory with Exception(s)

Indicator 3.8 Youth Records was rated Satisfactory

Indicator 3.10 Discharge and Follow Up was rated Satisfactory with Exception(s)

Domain 4: There are five indicators for Domain 4.

Indicator 4.0 SNAP® Under 12 was rated Satisfactory

Indicator 4.1 SNAP® Fidelity Monitoring was rated Satisfactory

Indicator 4.2 SNAP® for Youth was rated Not Applicable

Indicator 4.3 SNAP® Youth Justice was rated Satisfactory

Indicator 4.5 SNAP® for Schools and Communities was rated Satisfactory

Domain 5: There are five indicators for Domain 5.

Indicator 5.0 Shelter Program Services was rated Satisfactory

Indicator 5.1 Shelter Environment was rated Satisfactory with Exception(s)

Indicator 5.2 Shelter Search Policy was rated Satisfactory with Exception(s)

Indicator 5.3 Logbook Requirements was rated Limited

Indicator 5.4 Staffing Standards and Enhanced Supervision was rated Satisfactory

Indicator 5.5 Behavior Management Strategies was rated Satisfactory

Indicator 5.6 Program Orientation was rated Satisfactory

Indicator 5.7 Youth Room Assignment was rated Satisfactory

Indicator 5.8 Video Surveillance was rated Satisfactory

Domain 6: There are five indicators for Domain 6.

Indicator 6.0 Medication Management and Distribution was rated Satisfactory

Indicator 6.1 Naloxone Administration and Opioid Overdose Response was rated Satisfactory

Indicator 6.2 Suicide Prevention was rated Satisfactory with Exception(s)

Indicator 6.3 Healthcare Admission Screening was rated Satisfactory

Indicator 6.4 Medical/Mental Health Alert Process was rated Satisfactory

Summary of Deficiencies resulting in Limited or Failed Rating (If Applicable):**Domain 5:**

• 5.3 - Logbook Requirements: A total of eight samples were reviewed. Eight out of eight logged entries reviewed did not correctly perform documenting void, strike through, staff initials and date. After searching through the logbooks, it was found that the entries lack consistency in having supervisors or counselors reviewing and dating the logbooks. A total of eight entries were reviewed. Eight out of eight entries reviewed did not correctly perform documenting reviews at the beginning of shift since last entry. Agency is not making entries into logbook that capture supervisor and counselor dates in which they have documented dates reviewed in the logbook. Staff did not consistently document that they reviewed the logbooks before starting their shifts. An interview with the residential supervisor was conducted. She reported that while the supervisor does write the necessary information on the shift change document, it is not always documented in the program logbook. A review of the program logbook was conducted, no entries were found related to proper documentation of home visits. There were no indication that the youth were on specific home visits. Some entries mentioned off-site activities, but there were no actual records of home visits.

CINS/FINS QUALITY IMPROVEMENT TOOL		
<p>Quality Improvement Indicators and Results: Compliance: The findings observed or reviewed indicate the practice is aligned with the requirement(s) for the review item at the time of the review. Exception: The findings observed or reviewed indicate the practice is not aligned with the requirement(s) for the review item at the time of the review. Not Applicable: The item reviewed is not applicable for this review item(s) or the agency is not contracted to provide services related to the review item. E.g. If the agency has a policy that states they will not transport under any circumstance, Indicator 1.06 would be not applicable.</p>	<p>Summary/Narrative Findings: This column provides a comprehensive narrative summary of each assigned QI indicator. It highlights areas where the program demonstrated compliance, outlines the evidence supporting those determinations, and provides detailed explanations for any deficiencies or exceptions. Together, these findings offer clear justification for the specific domain ratings and present a balanced view of program performance.</p>	
Domain One – Background Screening and Compliance		
1.0 - Background Screening		Satisfactory with Exception(s)
Provider has a written policy and procedure that meets the requirement for Indicator 1.0	Yes	
Provider has implemented a Suitability Assessment policy and procedure that meets the requirement for Indicator 1.0	No	
	The agency has a policy titled 1.0 Background Screening. The policy was last approved by the CEO on 11/25/2025. Assessment is: Applicant Risk Profiler (developed by J. M. Llobet PHD)	
A total of 14 file(s) were reviewed during this evaluation period. Of these, 11 new hire file(s) and three 5-year rescreen file(s) were reviewed. The sample included 14 employee(s) and zero volunteer(s).		
Suitability Assessment		
All positions providing direct services (residential and community counseling) to youth has successfully passed pre-employment suitability assessment on the initial attempt.	Exception	The agency has a policy; however, the policy does not include verbiage pertaining to pass rate, score or measure for suitability of direct care staff working with youth. A review of the assessment tool does provide instructions on scoring. Two (2) assessments were not completed prior to or during staff hire. The agency's Human Resources Officer reported and verified that these two staff members did not complete an assessment.
For any applicant that did NOT pass the initial suitability assessment: Applicant retook the assessment and passed within five (5) business days of the initial attempt, not to exceed three (3) attempt within thirty (30) days.	Not Applicable	No staff members were found to not have passed the initial suitability assessment. Two of the eleven applicable staff did not take the assessment at time of hire.
Did the applicant pass the suitability assessment?	Compliance	All applicant files confirmed a passing result for the suitability assessment.

Employees who have a break in service may be reemployed with the same agency without an additional suitability assessment if the break is less than eighteen (18) months. However, if the provider changed or updated the assessment tool used, there is evidence that the employee completed the new assessment.	Not Applicable	No indication of sample of staff reviewed of an employee having a break in service.
New Hire		
For New Hires-The background screening was completed and the applicant was determined eligible prior to the date of hire.	Compliance	Background screenings for all new hires were completed, and eligibility was confirmed prior to each hire date.
For employee, contractor, volunteer, or intern who provide services for ten (10) or more hours per month-The background screening was completed and volunteer/mentor or intern determined eligible prior services being provided.	Not Applicable	No indication of sample of staff reviewed of having been a contractor, volunteer, or intern who provides services for ten or more hours per month.
For those with ineligible background screenings, the exemption was obtained prior to working with youth.	Not Applicable	No indication of staff with ineligible background screenings from staff reviewed.
E-Verify		
The file contains proof of E-Verify for all new employees obtained from the Department of Homeland Security.	Exception	E-Verify was conducted on 1/20/26 at 2:09PM. One staff member was not confirmed.
5 Year Rescreening		
Five year re-screening was completed prior to the 5-year anniversary date of initial hire or prior to expiration of retained fingerprints date.	Not Applicable	The agency has no eligible staff members due for a 5 year re-screening.
Additional Comments: There are no additional comments for this indicator.		
1.1 - Annual Affidavit of Compliance with Good Moral Character Standards		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.1		Yes
		The agency has a policy titled 1.1 Annual affidavit of compliance with good moral character standards. The policy was last approved on 11/25/2025.
Affidavit of Annual Compliance with Level 2 Screening Standard (Form IG/BSU-006) is completed and submitted to BSU by January 31st.	Compliance	The Affidavit of Annual Compliance with Level 2 Screening Standard (Form IG/BSU-006) was completed and submitted to BSU by the required deadline of January 31.
Affidavit of Annual Compliance with Level 2 Screening Standard was submitted sent to BSU by (at minimum): a. fax confirmation b. email confirmation	Compliance	Each affidavit submission included documented proof of delivery to BSU, verified through fax or email confirmation.

Additional Comments: There are no additional comments for this indicator.		
1.2 - Provision of an Abuse Free Environment		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.2		Yes The agency has a policy titled 1.2 Provision of an abuse-free environment. The policy was last reviewed by the CEO on 11/25/2025.
The program has a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation and there is evidence that it is provided to staff.	Compliance	The program maintains a formal code of conduct that strictly prohibits physical abuse, profanity, threats, intimidation, and other inappropriate behavior. The code of conduct is provided to all staff, with documented acknowledgment of receipt.
The Child Abuse Hotline number is clearly posted and visible for youth and staff to see.	Compliance	The Child Abuse Hotline number is clearly posted in visible locations accessible to both youth and staff.
The program has a process in place for reporting and documenting any child abuse hotline calls.	Compliance	The program has an established process for promptly reporting and documenting all child abuse hotline calls in accordance with state and agency policy. Staff are trained and compliant with reporting procedures.
The agency is an abuse free environment.	Compliance	Survey feedback confirms the agency maintains an abuse-free environment, with no reported concerns from completed surveys.
Additional Comments: There are no additional comments for this indicator.		
1.3 - Incident Reporting		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.3		Yes The agency has a policy titled 1.3 Incident reporting. The policy was last reviewed by the CEO on 11/25/2025.
Data sources Reviewed	Dates Reviewed	Logbook Dates for Sample Size:
CCC reports Incident reports Observation Logbooks	7/28/2025 - 1/28/2026	9/15/2025 - 1/28/2026
The program notified the Department’s CCC and reportable incidents were consistently reported as required, no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident.	Compliance	The program consistently reported incidents to the CCC within the required two-hour timeframe.
The program completes follow-up communication tasks/special instructions as required by the CCC.	Compliance	The program completed all follow-up communication and special instructions from the CCC.

Incidents are documented in the program logs, and the CCC call is documented in the logbook for Shelter programs.	Compliance	Incidents and CCC calls were documented in the program logs and logbooks as required.
Agency internal incidents are documented on incident reporting forms or electronically and all CCC reportable incidents were consistently reported to CCC as required.	Compliance	Agency internal incidents are consistently documented using approved incident reporting forms or electronic systems, and all CCC-reportable incidents are reported to the CCC in accordance with established requirements.
All incident reports are reviewed and signed by program supervisors/directors.	Compliance	All incident reports were reviewed and signed by program supervisors or directors.
Additional Comments: There are no additional comments for this indicator.		
1.4 - Training Requirements		Satisfactory with Exception(s)
Provider has a written policy and procedure that meets the requirement for Indicator 1.4	Yes	
	The agency has a policy titled Staff training and professional development. The policy was last reviewed by the CEO on 11/25/2025.	
A total of 0 first-year non-licensed Mental Health Clinical Shelter staff file(s) were reviewed. 4 new hire staff and 4 annual staff files were reviewed for compliance with training completed within the required timeframe(s).		
Policy & New Hire Training		
Trainings that are required by the Network and other funders must be documented in each individual staff member's file and on the FLN Training Log or similar document with the minimum requirements i.e. Staff Name & Position, Date of Hire, Training anniversary used by agency (calendar, date of hire or fiscal), Training Name, Training Hours, Cumulative Total, Training Completion or Facilitation Date, Location of Training or Platform Used (when virtual).	Compliance	All required trainings mandated by the Network and other funders are properly documented in each staff member's file and recorded on the FLN Training Log, including all required details such as staff information, training dates, hours, and completion records.
Civil Rights & Federal Funds (United States Department of Justice) (Required within 30 DAYS of date of hire)	Compliance	All staff, including full-time, part-time, and on-call employees, completed Civil Rights & Federal Funds (U.S. Department of Justice) training within 30 days of hire, ensuring compliance with federal requirements.
Pre-Service Training		
Agency policies and procedures	Compliance	All new staff completed agency orientation and policy training prior to working independently.
Contraband Overview and Search Policy/Practice AND signed acknowledgment form by staff.	Compliance	Staff reviewed the Contraband Overview and Search Policy and signed the required acknowledgment form.
Behavior Management	Compliance	Behavior Management training was completed prior to independent work with youth.

Building/Facility layout	Compliance	Staff received orientation to the building and facility layout.
File Documentation/Paperwork Requirements	Compliance	File documentation and paperwork requirement training was completed as required.
Confidentiality (FYSB / DCF / Skill Pro)	Compliance	Confidentiality training (FYSB / DCF / SkillPro) was completed and documented in staff files.
CCC & Incident Reporting	Compliance	Staff completed CCC and Incident Reporting training prior to working independently.
Child Abuse Reporting	Compliance	Child Abuse Reporting training was completed and verified in the staff record.
Client Intake & Screening	Compliance	Client Intake and Screening training was completed prior to independent case assignment.
Client Orientation (Shelter only)	Compliance	Staff completed Client Orientation training on delivering new client orientations.
Fire Safety Equipment (In-person by a supervisor or other program trainer)	Compliance	Fire Safety Equipment training was completed in person by a supervisor or program trainer.
Fire Safety Equipment (Skill Pro #215 or DCF)	Compliance	Fire Safety Equipment (SkillPro #215 or DCF) training completion is documented.
Medical and Mental Health Alert System	Compliance	Medical and Mental Health Alert System training was completed as required.
Disaster Preparedness	Compliance	Disaster Preparedness training was completed and verified in training logs.
Universal Precautions / Communicable Diseases / Infection Control / Bloodborne Pathogens Part I & II	Compliance	Universal Precautions, Communicable Diseases, Infection Control, and Bloodborne Pathogens Parts I & II training were completed and documented.
CPR/First Aid (By CPR Certified Instructor)	Compliance	CPR/First Aid training was completed by a certified instructor prior to independent duty.
Video Camera Surveillance & Equipment	Compliance	Staff completed Video Camera Surveillance and Equipment training prior to shift assignment.
CINS/FINS Core	Compliance	CINS/FINS Core training was completed and verified.
Crisis Intervention [e.g., MAB (2-day/16 hours)]	Compliance	Crisis Intervention training (e.g., MAB or FN-approved equivalent) was completed and documented.
Florida Network Youth Suicide Prevention	Compliance	Florida Network Youth Suicide Prevention training was completed within the required timeframe.
Adolescent Development / Positive Youth Development	Compliance	Adolescent Development and Positive Youth Development training were completed and recorded.
Cultural Humility/Diversity	Compliance	Cultural Humility and Diversity training was completed through an approved provider (Bridge or RHYTTAC).
Mental Health and Substance Abuse	Compliance	Mental Health and Substance Abuse training was completed and documented in the staff record.
Skill Pro Required Trainings:		
Child Abuse: Recognition, Reporting and Prevention	Compliance	Staff completed Child Abuse: Recognition, Reporting, and Prevention training within the first 90 days of employment or service.

Equal Employment Opportunity	Compliance	Equal Employment Opportunity training was completed and documented within the first 90 days.
Human Trafficking Intervention for Direct Care Staff	Compliance	Human Trafficking Intervention for Direct Care Staff training was completed as required.
Information Security Awareness	Compliance	Information Security Awareness training was completed within the required timeframe.
Prison Rape Elimination Act (PREA) - Part 1	Compliance	Prison Rape Elimination Act (PREA) – Part 1 training was completed and documented in staff records.
Prison Rape Elimination Act (PREA) - Part 2	Compliance	Prison Rape Elimination Act (PREA) – Part 2 training was completed and verified in the staff file.
Sexual Harassment	Compliance	Sexual Harassment training was completed within the first 90 days of employment or service.
Trauma Responsive Practices	Compliance	Trauma Responsive Practices training was completed and documented as required.
Additional FL Network Required Trainings:		
Naloxone Training	Compliance	Naloxone training was completed and documented within the first 90 days of employment or service.
Adverse Childhood Experiences (ACEs) (Required for All Staff not completing NIRVANA)	Compliance	Adverse Childhood Experiences (ACEs) training was completed by all staff not participating in NIRVANA® training.
FL Statute 984 CINS Petition Training (Case Staffing & CINS Petition Staff Only)	Not Applicable	No staff in sample required to complete this type training.
STAFF SPECIFIC TRAINING - Florida Network and SkillPro Required Trainings Related to Specific Staff Roles		
JJIS (Juvenile Justice Information System) System Access (Required for staff who enter and monitor SVS prior to accessing JJIS)	Not Applicable	No staff in sample required to complete this type training.
JJIS Alerts – Part 1 (JJIS Data Entry Staff prior to accessing JJIS)	Not Applicable	No staff in sample required to complete this type training.
JJIS Alerts – Part 2 (JJIS Data Entry Staff prior to accessing JJIS)	Not Applicable	No staff in sample required to complete this type training.
Motivational Interviewing (MI) (Prior to NIRVANA training for Staff who Administer the NIRVANA)	Not Applicable	No staff in sample required to complete this type training.
NIRVANA Assessment (Required for all staff who Administer the NIRVANA, prior to administering the NIRVANA)	Not Applicable	No staff in sample required to complete this type training.

Medication Distribution for Shelter Staff Without a Medical License (Prior to administration of medication and annually)	Compliance	Shelter staff without a medical license completed Medication Distribution training prior to administering medication and renewed annually.
PYXIS (Authorized Shelter Staff prior to accessing Pyxis system)	Compliance	Authorized shelter staff completed PYXIS training prior to accessing the Pyxis system.
SNAP Support Overview *This training does not certify staff to facilitate SNAP After completing training, this Supporter must only be paired with a fully trained SNAP Facilitator	Not Applicable	No staff in sample required to complete this type training.
SNAP Facilitator Training (Required for All Staff prior to the delivery of Groups)	Not Applicable	Provide training proof of training for SNAP staff.
NetMIS Training (For NetMIS Users prior to accessing NetMIS)	Not Applicable	No staff in sample required to complete this type training.
NON-LICENSED CLINICAL STAFF ONLY Staff Suicide Assessment Training ** 20 hours including a minimum of five (5) one-to-one assessments of suicide risk in the physical presence of a licensed professional. This training is documented and maintained in the staff person's personnel file using the Documentation of Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk form. (Required for All shelter staff who are not licensed prior to independent assessment of suicide risk)	Not Applicable	No staff in sample required to complete this type training.
NON-LICENSED CLINICAL STAFF ONLY 16 hours clinical training + 36 hours topic-specific training (Covering: basic counseling skills, basic group therapy skills, treatment model and program philosophy, therapeutic milieu, behavior management, client rights, crisis intervention, early intervention and de-escalation, documentation requirements, normal and abnormal adolescent development, typical behavior problems) * Prior to working with youth*	Not Applicable	No staff in sample required to complete this type training.

<p>NON-LICENSED CLINICAL STAFF ONLY Mental health and substance-related disorders; Counseling theory and techniques; Group dynamics and therapy; Treatment and discharge planning. (Required for Bachelor’s level non-licensed counseling staff without 2 years clinical experience assessing, counseling or treating youth with serious emotional disturbance or substance abuse problems) *To be completed during first year of employment*</p>	<p>Not Applicable</p>	<p>No staff in sample required to complete this type training.</p>
<p>For any trainings that are NOT completed within the required timeframe, includes documentation of the reason and scheduled completion date.</p>	<p>Not Applicable</p>	<p>No staff in sample were applicable for this area.</p>
<p>Direct Care staff (full-time, part-time, and on-call) complete all pre-service requirements prior to working independently and achieve a minimum of 80 hours of training during their first year.</p>	<p>Compliance</p>	<p>Direct-care staff completed all pre-service requirements prior to working independently and achieved at least 80 hours of training within their first year.</p>
<p>If there was a break in employment for less than six (6) months, the file contains documentation confirming the supervisor reviewed applicable prior training and verified completion.</p>	<p>Not Applicable</p>	<p>No staff in sample were applicable for this area.</p>
<p>If the agency finds that the instructor is not available for the instructor led course within the required timeframe, then document attempts in the staff training file.</p>	<p>Not Applicable</p>	<p>No indication of issues or concerns with staff training instructor.</p>
<p>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.</p>	<p>Compliance</p>	<p>The agency has a designated staff member responsible for managing all employee training files and routinely reviews them to ensure compliance.</p>
<p>All Network-required training is supported by documentation such as certificates, sign-in sheets, and agendas.</p>	<p>Compliance</p>	<p>All Network-required trainings are supported by appropriate documentation, including certificates, sign-in sheets, and training agendas.</p>
<p>Annual Training</p>		

Trainings that are required by the Network must be documented in each individual training file or employee file as well as captured on the FLN Training Log or similar document with the minimum requirements (i.e. Staff Name & Position, Date of Hire, Training anniversary used by agency (calendar, date of hire or fiscal), Training Name, Training Hours, Training Completion or Facilitation Date, Location of Training or Platform Used (when virtual), and Cumulative Total Training Hours)	Compliance	All Network-required trainings are documented in individual staff files and recorded on the FLN Training Log with all required details, including staff information, training hours, completion dates, and cumulative totals.
Child Abuse: Recognition, Reporting, and Prevention (Annually)	Compliance	Child Abuse: Recognition, Reporting, and Prevention training is completed annually and properly documented in staff training records.
Human Trafficking Intervention for Direct-Care Staff (Annually)	Compliance	Human Trafficking Intervention for Direct-Care Staff training is completed annually and supported by required documentation.
Information Security Awareness (Annually)	Compliance	Information Security Awareness training is completed annually and verified through certificates or attendance records.
Prison Rape Elimination Act (PREA) Part 1 (Every 2 years)	Compliance	Prison Rape Elimination Act (PREA) Part 1 training is completed every two years and properly documented in training files.
Prison Rape Elimination Act (PREA) Part 2 (Every 2 years)	Compliance	Prison Rape Elimination Act (PREA) Part 2 training is completed every two years and supported by appropriate documentation.
Sexual Harassment (Every 2 Years)	Compliance	Sexual Harassment training is completed every two years and verified in staff files.
Trauma Responsive Practices (Every 2 Years)	Compliance	Trauma Responsive Practices training is completed every two years and documented on the FLN Training Log and in staff training files.
FL Network Annual Required Trainings REQUIRED for Staff Over 1 year		
Florida Network Youth Suicide Prevention (Required Annually)	Compliance	Florida Network Youth Suicide Prevention training is completed annually and documented in staff training files.
CPR (Every 2 Years - Check for current validity)	Compliance	CPR certification is current and renewed every two years in accordance with Network requirements.
First Aid (Every 2 Years - Check for current validity)	Compliance	First Aid certification is current and renewed every two years, with documentation maintained in the staff file.
Crisis Intervention training approved by the Network (ex: Managing Aggressive Behavior (MAB) (Every 2 Years)	Compliance	Crisis Intervention training (e.g., Managing Aggressive Behavior – MAB) is completed every two years as approved by the Network.
In-Person Fire Safety Equipment (Every 2 years)	Exception	Per the agency's shelter supervisor, the shelter has not conducted annual fire safety training. Four of four staff records missing fire safety training.
Virtual Fire Safety Equipment (Every 2 years)	Compliance	Virtual Fire Safety Equipment training is completed every two years and properly documented.
Medication Distribution for Staff Without a Medical License (Re-certification annually)	Compliance	Medication Distribution training for staff without a medical license is re-certified annually and verified through documentation.

SNAP Refresher Training (Annually for all staff who have completed SNAP Facilitator Training and are delivering SNAP group services or monitoring fidelity)	Not Applicable	No staff in sample were applicable for this training.
For missed trainings, documentation includes the reason for delay and scheduled completion timeline.	Exception	Per shelter supervisor, the shelter has not conducted annual fire safety training. Four of four staff records missing fire safety training.
All direct care Community Counseling staff meet the annual requirement of a minimum of 24 hours of total hours of training hours received for the year.	Not Applicable	No staff in sample were applicable for this training.
All direct care Shelter Staff meet the annual requirement of a minimum of 40 hours for residential programs licensed by DCF of the total hours of training received for the year. *This includes residential counselor or other direct care staff positions working with youth in shelter.*	Compliance	All direct-care Shelter staff meet the annual minimum requirement of 40 total training hours, as required for residential programs licensed by DCF.
Annual and Biannual training must be due on a calendar or fiscal year basis, not based on hire date.	Compliance	Annual and biannual training schedules are tracked and completed based on the agency's established calendar or fiscal year cycle, not hire date.
All Network-required training is supported by documentation such as certificates, sign-in sheets, and agendas.	Compliance	All Network-required trainings are supported by documentation such as certificates, sign-in sheets, and training agendas.
Additional Comments: There are no additional comments for this indicator.		
1.5 - Data Entry & Collection		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.5		Yes
		The agency has a policy called 1.5 Data Entry and Collection. The policy was revised on 10/9/2025. The CEO reviewed and signed the policy on 2026.11/25/2025.
The program has a quality improvement process in place that includes designated staff responsibilities to ensure data accuracy and quality.	Compliance	The program maintains an active quality improvement process to review and enhance the accuracy of data entry and collection.
Client and service data is entered electronically into the Florida Network Management Information System (NetMIS) within three (3) business days of service commencement.	Compliance	Client and service data are entered electronically into the Florida Network Management Information System (NetMIS) within three (3) business days of service commencement, as verified in the most recent End-of-Month (EOM) report.

<p>Monthly review of statewide End-of-Month ('EOM') reports is evidenced (via meeting minutes/agendas). This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, and follow-up reporting measures.</p>	<p>Compliance</p>	<p>Monthly review of statewide End-of-Month (EOM) reports is completed and documented, including analysis of monthly data, fiscal year-to-date data, benchmarks, screening metrics, report card measures, and follow-up reporting indicators</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>1.6 - Risk Management/ Analyzing and Reporting Information</p>	<p>Satisfactory with Exception(s)</p>	
<p>Provider has a written policy and procedure that meets the requirement for Indicator 1.6</p>	<p>Yes</p>	
	<p>The agency has a policy called 1.6 Analyzing and Reporting. The policy was revised on 10/9/2025. The CEO reviewed and signed the policy on 11/25/2025.</p>	
<p>Data sources Reviewed</p>	<p>Dates Reviewed</p>	
<p>Interviewed the agency's CEO, COO, Intake Coordinator</p>	<p>The agency has a policy called 1.6 Analyzing and Reporting. The policy was last revised on 10/9/2025. The CEO reviewed and signed the policy on 1/25/2025.</p>	
<p>The program provides reports of aggregated data and committee/workgroup minutes analyzing information.</p>	<p>Compliance</p>	<p>The program consistently compiles and maintains aggregated data reports and meeting minutes from committees and workgroups, demonstrating active analysis and ongoing program improvement.</p>
<p>The program conducts quarterly case record reviews. (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.)</p>	<p>Exception</p>	<p>The agency did not have evidence of conducting quarterly case reviews.</p>
<p>The program reviews incidents, accidents, and grievances at least quarterly.</p>	<p>Compliance</p>	<p>The program conducts regular reviews of all incidents, accidents, and grievances at least quarterly, ensuring timely analysis, corrective actions, and preventive measures.</p>
<p>The program reviews customer satisfaction data at least annually.</p>	<p>Compliance</p>	<p>Customer satisfaction data is reviewed annually, and feedback is used to enhance service quality and client experience.</p>
<p>The program reviews outcome data at least annually.</p>	<p>Compliance</p>	<p>Program outcome data is reviewed annually to assess performance against goals and inform quality improvement efforts.</p>
<p>There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.</p>	<p>Compliance</p>	<p>Findings from reviews are consistently evaluated by management and effectively communicated to staff and stakeholders to ensure transparency and alignment.</p>

The program demonstrates 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 provider's Executive Committee on the Board of Directors.	Compliance	Program performance is routinely presented to the Board of Directors. All final reports receiving a Limited or Failed rating are submitted to the Executive Committee electronically or by mail, as required.
Evidence shows that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	Compliance	Documentation reflects that program strengths and weaknesses are identified, corrective actions implemented, and staff are informed and engaged throughout the improvement process.
Additional Comments: There are no additional comments for this indicator.		
1.7 - Client Transportation	Satisfactory with Exception(s)	
Provider has a written policy and procedure that meets the requirement for Indicator 1.7	Yes	
	The agency has a policy titled 1.7 Transportation of youth. The policy was last approved by the CEO on 11/25/2025.	
Supervisors complete a weekly review of transport documentation and provide written feedback or coaching when deficiencies are found.	Exception	Per COO - There are no documented quarterly reviews which have been conducted over the annual compliance review period. The maintenance mechanic does address any vehicle discrepancies when identified. The new FOP addresses weekly reviews by supervisory staff of transport documentation.
The agency has a practice, review, and approval process in place regarding the transportation of youth assigned to the program.	Compliance	The agency maintains an established transportation policy and formal approval process that governs all youth transports, ensuring safety and accountability.
All drivers have an approved driver's license.	Compliance	All approved drivers hold valid driver's licenses verified by the agency prior to transporting youth.
List of approved drivers eligible to drive client(s) for the agency or approved private vehicle that considers the driver's work performance and history, indicating no inappropriate behavior is likely to occur.	Compliance	The agency maintains a current list of approved drivers eligible to transport clients, confirming each driver's satisfactory work performance and history free from inappropriate behavior.
The list of approved drivers are covered under the agency's automobile insurance.	Compliance	All approved drivers are covered under the agency's automobile insurance policy, and verification of coverage is maintained on file.
There is documentation of use of a vehicle that notes the name or initials of the driver, date and time, mileage, number of passengers, purpose of travel, and location.	Compliance	Vehicle logs consistently record the driver's name or initials, date, time, mileage, number of passengers, travel purpose, and destination, providing complete accountability for all transports.
Signed parental consent is obtained in advance of any single transport.	Not Applicable	Per the COO no single transports conducted during this review period.

<p>If a single staff is transporting youth in a vehicle, there is evidence that the Program Director approved it (prior to the transport) and the approval is documented accordingly prior to the client transport.</p>	<p>Not Applicable</p>	<p>Per the COO no single transports conducted during this review period.</p>
<p>If there is no signed parental consent for single staff transport and the transport is necessary and cannot be delayed; in addition to the single staff transportation requirements above, there is evidence that the transporting employee completed a check-in by phone at agreed-upon intervals with the senior program leader or designee, upon departure and arrival. The employee check-ins must be documented by the manager or designee receiving the call.</p>	<p>Not Applicable</p>	<p>Per the COO no single transports conducted during this review period.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>1.8 - Client Contact Policy</p>		<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 1.8</p>	<p>Yes</p>	
	<p>The agency has a policy called 1.8 Client Contact. The policy was revised on 10/9/2025. The CEO reviewed and signed the policy on 11/25/2025.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>1.9 - Community Referrals and Outreach Services</p>		<p>Satisfactory with Exception(s)</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 1.9</p>	<p>Yes</p>	
	<p>The agency has a policy called 1.9. The policy was revised on 10/9/2025. The CEO reviewed and signed the policy on 11/25/2025.</p>	
<p>Outreach activities include education about services offered and guidance on accessing those services.</p> <p>The following mandatory information of each outreach activity is entered into NETMIS: the title, date, duration (hours), zip code, location, description, estimated number of people reached, modality, target audience and topic.</p> <p>The activities include group presentations/discussions, individual meetings, short-term intervention groups, set up/display and distribution of materials at community events, conducting tours of facilities, and media events or interviews.</p>	<p>Compliance</p>	<p>The program’s outreach activities effectively educate the community about available services and provide clear guidance on how to access them. All required details, including title, date, duration, location, description, estimated attendance, modality, target audience, and topic, are accurately entered into NETMIS.</p>

<p>The program has evidence that provides minutes of the event or other verification of staff participation.</p>	<p>Compliance</p>	<p>Documentation such as meeting minutes, sign-in sheets, and event summaries confirm active staff participation in all outreach activities.</p>
<p>The program has a lead staff member who conducts outreach, is designated to participate in local DJJ Board and council meetings and leads other outreach activities.</p>	<p>Compliance</p>	<p>A designated staff member serves as the program’s outreach lead, participates in local DJJ Board and council meetings, and coordinates all outreach efforts on behalf of the program.</p>
<p>This responsibility is specified in their job description.</p>	<p>Compliance</p>	<p>The outreach lead’s job description clearly defines responsibility for community engagement, DJJ participation, and oversight of outreach activities.</p>
<p>Full-Service agencies document meetings with local stakeholders (school districts, judges, and law enforcement) at least two times per year to discuss services available and needed improvements.</p>	<p>Compliance</p>	<p>Full-service agencies maintain ongoing collaboration with key stakeholders, including school districts, judges, and law enforcement, and meet at least twice per year to review services and discuss opportunities for improvement.</p>
<p>Outreach activities include education about services offered and guidance on accessing those services. The program has evidence that provides minutes of the event or other verification of staff participation.</p>	<p>Compliance</p>	<p>Outreach efforts include a variety of engagement methods such as group presentations, individual meetings, short-term intervention groups, informational displays at community events, facility tours, and media participation. These activities demonstrate strong community visibility and connection.</p>
<p>The program maintains written agreements with other community partners, which include services provided and a comprehensive referral process.</p>	<p>Compliance</p>	<p>The program maintains current written agreements with community partners outlining provided services and a clearly defined referral process that supports coordinated care.</p>
<p>Copies of agreements are forwarded to the Florida Network.</p>	<p>Exception</p>	<p>The agency has active interagency agreements with Agency for Health Care Administration, Agency for Persons with Disabilities, Department of Children and Families, Department of Justice, Department of Education, Department of Health, Guardian Ad Litem, Office of Early Learning, Red Cross, Marion School Board, Lake County School Board, Department of Health, Ocala Police Department, Lake County and Marion County Sheriff Departments. Agency did not provide evidence of copies of agreements were forwarded to the FNYFS.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		

Domain Three		
3.2 - Admission Process	Satisfactory	
Provider has a written policy and procedure that meets the requirement for Indicator 3.2	Yes	
	The program has a policy, 3.2/ Admission Process, that meets all requirements of the indicator. The policy was last revised on 10/15/25 and reviewed on 11/25/25 by CEO.	
A total of ten file(s) were reviewed during this evaluation period. Of these, four were open and six were closed. Among the open file(s), two residential (RES) and two community counseling file(s) were reviewed. Among the closed file(s), three residential (RES) and three community counseling file(s) were reviewed.		
The screening form is completed immediately for all inquiries into shelter placement.	Compliance	For all inquiries into shelter placement, screening forms were completed immediately by trained staff, ensuring timely assessment and appropriate service placement.
<u>For Community Counseling Services:</u> The initial screening for eligibility for Community Counseling Services (including screening for eligibility, crisis counseling and information, and referral) occurs within 3 business days of referral by a trained staff member using, at minimum, the Florida Network screening form.	Compliance	Initial screenings for Community Counseling Services were completed within three business days of referral by trained staff using the Florida Network screening form. All eligibility, crisis, and referral requirements were met.
Youth and parents/guardians receive the following in writing		
Youth and parents/guardians are provided available service options in writing.	Compliance	Youth and parents/guardians were provided written information outlining all available service options, ensuring informed decision-making about participation.
Youth and parents/guardians are provided “Rights and Responsibilities of Youth” in writing.	Compliance	Written materials detailing the rights and responsibilities of youth were provided at intake, and documentation confirmed receipt in all reviewed files.
Parents/guardians are provided “Rights and Responsibilities of Parents” and/or parent brochure.	Compliance	Parents and guardians were provided the “Rights and Responsibilities of Parents” brochure at intake, and signed acknowledgment forms were present in all records.
The following is also available to the youth and parents/guardians:		
Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication).	Compliance	Youth and parents/guardians received written information describing possible outcomes and actions that may occur through involvement with CINS/FINS services, including case staffing, petitions, and adjudications.

Youth and parents/guardians are provided information regarding the programs grievance procedures.	Compliance	All youth and parents/guardians were informed of the program’s grievance procedures, and documentation confirmed this information was reviewed and acknowledged.
If the youth and family do NOT participate in services, the reason is documented on the screening form and logged in NetMIS.	Not Applicable	Ten out of ten files reviewed were not applicable, as all families participated in services.
The intake took place in a setting that allows the client to feel safe and heard.	Compliance	Intakes were conducted in private, trauma-informed settings designed to help youth feel safe, respected, and heard throughout the process.
Additional Comments: There are no additional comments for this indicator.		
3.3 - NIRVANA (Network Inventory of Risks, Victories, and Needs Assessment)		Satisfactory with Exception(s)
Provider has a written policy and procedure that meets the requirement for Indicator 3.3		Yes
		The program has a policy, 3.3/ NIRVANA, that meets all requirements of the indicator. The policy was last revised on 10/15/25 and reviewed on 11/25/25 by CEO.
For youth in shelter care: NIRVANA Assessment initiated within 72 hours of admission.	Exception	Three out of five residential files reviewed did not have documentation of NIRVANA initiation within 72 hours of intake. Two out of five residential files reviewed had documentation of NIRVANA initiation within 72 hours of intake.
For youth in shelter care: NIRVANA Assessment is completed within seven (7) days from intake.	Compliance	All NIRVANA Assessments for shelter youth were completed within seven days of intake, confirming timely completion of assessment requirements.
NIRVANA Assessment is completed within one to two contacts following the initial intake date into services.	Compliance	All Community Counseling NIRVANA Assessments were completed within one to two contacts after intake, consistent with Florida Network guidelines.
NIRVANA Assessment is initiated at intake.	Compliance	All components of the NIRVANA process initiation were fully compliant and supported by documentation in each file.
NIRVANA Assessment was conducted by a bachelor’s or master’s degree staff who has completed the Florida Network NIRVANA training and has had Motivational Interviewing (MI).	Compliance	All assessments were completed by qualified bachelor’s or master’s level staff who successfully completed both NIRVANA and Motivational Interviewing training, verified through the staff roster.
All completed NIRVANA assessments are entered electronically into the Florida Network Management Information System (NetMIS) within three (3) business days of service commencement.	Exception	One NIRVANA assessment was entered into NETMIS outside of the three business days.

The supervisor's signature is documented on the completed NIRVANA Assessment and/or the chronological note and/or the interview guide that is located in the youths' file within 7 business days.	Compliance	Supervisor signatures were documented within seven business days on all completed NIRVANA Assessments, confirming management review and approval.
(Shelter only) NIRVANA Self-Assessment Report (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	Compliance	For all shelter admissions, the NIRVANA Self-Assessment Report (NSR) was completed within 24 hours, with any exceptions fully documented in NetMIS and the youth's file.
A NIRVANA Post-Assessment is completed at discharge for youth who have a length of stay that is greater than 30 days.	Compliance	All youth with stays exceeding 30 days received a completed NIRVANA Post-Assessment at discharge to measure progress and outcomes.
A NIRVANA Re-Assessment is completed every 90 days with the exception of SNAP services.	Not Applicable	Five out of five residential files reviewed and five of five community counseling files were not applicable for this indicator, as none of the cases were opened for 90 days following initial NIRVANA completion.
All files must have the interview guide and/or printed NIRVANA.	Compliance	Each file reviewed contained a completed interview guide and/or a printed copy of the NIRVANA Assessment, demonstrating proper documentation and retention.
Additional Comments: There are no additional comments for this indicator.		
3.4 - Case Management, Counseling & Non-Residential Services Policy		Satisfactory with Exception(s)
Provider has a written policy and procedure that meets the requirement for Indicator 3.4		Yes
		The program has a policy, 3.7/ Service Plan, that meets all requirements of the indicator. The policy was last revised on 10/15/25 and reviewed on 11/25/25 by CEO.
Each client is assigned a Counselor.	Compliance	Each client was assigned a qualified counselor responsible for coordinating services and maintaining consistent therapeutic engagement.
The following is also available to the youth and parents/guardians:		
In the Shelter Program: Counseling services are provided to each client at least once per week, for the first 12 weeks of services, by a licensed mental health professional or non-licensed staff with clinical experience or has completed the required clinical training working under the direct supervision of a licensed staff member.	Compliance	In the Shelter Program, individual and/or family counseling sessions were provided at least once per week by a licensed mental health provider or by unlicensed staff under the supervision of a licensed clinician.

<p>Community Counseling Program: Counseling services are provided to each client at least once per week, for the first 12 weeks of services, by a licensed mental health professional or nonlicensed staff working under the direct supervision of a licensed staff. <i>(May include Individual, group, and family counseling, Crisis intervention, Parent training, Community-based mental health and substance abuse referrals, Case management, Prevention and diversion services, Skills training, tutorial/remedial services, Vocational, job training, or employment services, and Recreational services)</i></p>	<p>Compliance</p>	<p>In the Community Counseling Program, counseling sessions were offered weekly, meeting requirements for service frequency and modality, including individual, group, and family sessions as well as crisis intervention, skills training, and referrals.</p>
<p>The reason(s) why a required weekly session could not be provided is documented in the youth's file and in NetMIS.</p>	<p>Not Applicable</p>	<p>Five out of five residential files and five out of five community counseling files reviewed were not applicable for this indicator, as all youths received weekly counseling services.</p>
<p>If case management needs extend beyond the counselor's role, a case manager is assigned.</p>	<p>Not Applicable</p>	<p>Five out of five residential files and five out of five community counseling files reviewed were not applicable for this indicator, as case management needs did not extend past counselor's role.</p>
<p>Case Manager establishes appropriate referrals to services.</p>	<p>Not Applicable</p>	<p>Five out of five residential files and five out of five community counseling files reviewed were not applicable for this indicator, as case managers were not assigned.</p>
<p>All counseling and case management sessions are documented in the youth's file and NetMIS, including the reason for missed sessions.</p>	<p>Exception</p>	<p>Five out of five residential files reviewed did not have all sessions documented in both the youth file and NetMIS. Initially when reviewed, three of five community counseling files reviewed had sessions properly documented in both locations; two of five did not. Counselors were able to verify community counseling services directly from their files and update any missing entries in NetMIS immediately on-site during the review.</p>
<p>If mental health or substance abuse needs, outside of the program's capacity, are identified appropriate referrals are made and documented.</p>	<p>Not Applicable</p>	<p>Five out of five residential files and five of five community counseling files were not applicable for this indicator, as there were no mental health or substance abuse needs.</p>

<p>For youth receiving Respite Services (DV, Probation & PDC): A minimum of one family counseling session is offered to address reunification planning and related concerns. If the session is not conducted, the reason is documented in the youth's case file, including any barriers to participation or service delivery.</p>	<p>Compliance</p>	<p>For youth in Respite Services (DV, Probation, or PDC), at least one family counseling session was offered to support reunification planning. When sessions did not occur, reasons and barriers were clearly documented in the youth's file.</p>
<p>Clients that do not receive services for 30 days or more have their case closed.</p>	<p>Not Applicable</p>	<p>Ten out of ten files reviewed were not applicable for this indicator, as no cases did not receive services for a 30 day period.</p>
<p>Direct supervision is documented on the Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log (MHSA 019) or on a program developed form which contains the same information.</p>	<p>Exception</p>	<p>After interview with Clinical Supervisor and review of supervision logs across all 10 client cases, it was determined that direct supervision by a LMHP for non-licensed mental health clinical staff has not been completed consistently on a weekly basis.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>3.5 - Adjudication Services: Case Staffing</p>		<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 3.5</p>		<p>Yes</p>
		<p>The Program has a written policy and procedure that meets all of the requirements for the indicator, it is Policy # 3.5 Adjudication Services: Case Staffing; Revised 10/15/25; Last Reviewed 11/25/25 by CEO</p>
<p>A total of two file(s) were reviewed during this evaluation period. Of these, two were open and zero were closed. Among the open file(s), zero residential (RES) and two community counseling file(s) were reviewed. Among the closed file(s), zero residential (RES) and zero community counseling file(s) were reviewed.</p>		
<p>A case staffing committee meeting is scheduled when one of the following occur (at minimum):</p> <ol style="list-style-type: none"> 1. the youth/family is not in agreement with services or treatment; 2. the youth/family will not participate in the services selected, 3. the youth's referring problem has not shown substantial improvement within six weeks of initiating counseling. 4. the program receives a written request from the parent/guardian or any other member of the committee 	<p>Compliance</p>	<p>Case staffing committee meetings are scheduled as required when the youth or family is not in agreement with services, will not participate, demonstrates limited progress within six weeks, or upon written request from the parent/guardian or committee member.</p>
<p>Each case staffing must be recorded in NetMIS within the case, noting the date it occurred.</p>	<p>Compliance</p>	<p>Each case staffing is accurately recorded in NetMIS within the case record, including the date of occurrence.</p>

The case staffing is convened within 7 days (excluding weekends and legal holidays) of the parent/guardian request.	Not Applicable	Parents did not request a case staffing in either of the two files reviewed, as one was court ordered and the other one was referred by the school.
Notification to the family is sent no less than 5 working days prior to staffing.	Compliance	Families receive written notification of the staffing meeting at least five (5) working days prior to the scheduled date.
Notification to the committee is sent no less than 5 working days prior to the staffing date.	Compliance	Committee members receive notification of the staffing meeting at least five (5) working days in advance.
A written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations.	Compliance	A written report is provided to the parent or guardian within seven (7) days of the staffing meeting, outlining recommendations and the rationale for each.
As a result of the case staffing committee meeting, the youth and family are provided a new or revised plan for services.	Not Applicable	Not applicable due to being new referrals. One was court-ordered referral and one was referral by the school.
At a minimum, the case staffing is attended by:		
Local school district representative	Compliance	Each case staffing includes attendance by a local school district representative as required.
DJJ rep. or CINS/FINS provider	Compliance	A DJJ representative or CINS/FINS provider participates in each case staffing meeting in accordance with established guidelines.
Other members may include:		
State Attorney’s Office	Compliance	A representative from the State Attorney’s Office participates in case staffing meetings as appropriate.
Mental health representative	Compliance	A mental health representative participates in case staffing meetings when applicable.
Substance abuse representative	Not Applicable	This system partner was not applicable for this case.
Law enforcement representative	Compliance	A law enforcement representative participates in case staffing meetings when appropriate.
DCF representative	Not Applicable	This system partner was not applicable for this case.
Others requested by youth/family	Not Applicable	This system partner was not applicable for this case.
The program has an established case staffing committee and has regular communication with committee members.	Compliance	The program maintains an established case staffing committee with active and consistent communication among all members.

The program has an established case staffing committee, and has regular communication with committee members.	Compliance	Regular collaboration and communication with case staffing committee members are maintained to ensure coordinated planning and support for youth and families.
Additional Comments: There are no additional comments for this indicator.		
3.6 - Adjudication Services: CINS Petition Process	Satisfactory	
Provider has a written policy and procedure that meets the requirement for Indicator 3.6	Yes	
	The Program has a written policy and procedure that meets all of the requirements for the indicator, it is Policy #3.6 Adjudication Services: CINS Petition Process; Revised 10/15/25; Last Reviewed 11/25/25 by CEO	
If applicable, the program works with the circuit court for judicial intervention for the youth/family, as applicable, including required attendance at all court hearings without subpoena.	Not Applicable	One of two case files reviewed showed evidence of the program working with the circuit court for judicial intervention for the youth/ family.
The Case Manager/Counselor completes a review summary prior to the court hearing for a youth.	Not Applicable	One of the two case files reviewed involved judicial intervention, and a summary of this involvement is documented in the file prior to court hearing.
Additional Comments: There are no additional comments for this indicator.		
3.7 - Service Plan	Satisfactory with Exception(s)	
Provider has a written policy and procedure that meets the requirement for Indicator 3.7	Yes	
	The program has a policy, 3.7/ Service Plan, that meets all requirements of the indicator. The policy was last revised on 10/15/25 and reviewed on 11/25/25 by CEO.	
A Case/Service Plan is developed within seven (7) working days of the youth's intake in the shelter program.	Compliance	The Case/Service Plan is completed within seven working days of intake, ensuring timely service initiation.
A Case/Service Plan is developed within one contact following the completion of the NIRVANA in the community counseling program.	Compliance	The Case/Service Plan is completed within one contact of the NIRVANA, demonstrating prompt follow-up and coordination.
The plan is developed on a local provider approved form or through NETMIS based on information gathered during initial screening, intake, and NIRVANA.	Compliance	The Case/Service Plan is completed using approved provider forms or NETMIS, based on information from screening, intake, and NIRVANA.
Youth and parents/guardians receive the following in writing		

The Case/Service Plan reflects the individualized and prioritized needs and goals identified during the assessment process, including relevant domains from the NIRVANA.	Compliance	Individualized and prioritized needs and goals are clearly identified based on the assessment process, incorporating all relevant domains from the NIRVANA.
Each plan clearly documents the type of service(s) to be provided, the frequency, and the location of services.	Compliance	Each plan clearly outlines the type, frequency, and location of services to ensure structured and consistent service delivery.
The plan identifies the person(s) responsible for implementing each service or action step.	Compliance	The plan specifies the person(s) responsible for implementing each service or action step, promoting accountability and effective follow-through.
The target date(s) for completion are documented in the service plan for each identified goal.	Compliance	Each plan includes clear target date(s) for goal completion, supporting timely progress monitoring and accountability.
The actual completion date(s) are documented in the service plan for each identified goal.	Compliance	Actual completion date(s) are consistently recorded, demonstrating effective tracking of service delivery and goal attainment.
The signature of the youth is documented in the service plan.	Compliance	Youth signatures are present on plans, confirming their participation and agreement with the identified goals and services.
The signature of the parent/guardian is documented in the service plan.	Exception	Four out of five residential files reviewed and five out of five community counseling files reviewed had plans with the parent/guardian signature. One out of five residential files reviewed did not have a plan with a parent/guardian signature.
If unavailable, the absence is documented with a reason on the plan.	Exception	One out of five residential files reviewed did not have a plan with a document reason for the absence of the parent/guardian signature. Four out of five residential files reviewed were not applicable, as the plans had parent/guardian signatures documented. Five out of five community counseling files reviewed were not applicable, as parent/guardian signature was were documented.
The signature of the counselor is documented in the service plan.	Compliance	Counselor signatures are included on all plans, verifying professional oversight and approval of service goals and actions.
The signature of the LMHP reviewing the plan is signed within seven (7) days of plan completion.	Compliance	The plan includes the LMHP's signature within seven days of completion, confirming timely clinical review and oversight.
The date of plan initiation is clearly indicated.	Compliance	The date of plan initiation is clearly documented, ensuring clarity on when services and interventions began.

The Case/Service Plan is formally reviewed and revised in collaboration with the youth and parent(s)/guardian(s):		
At, 30 Days, following plan initiation.	Exception	Five out of five residential files reviewed were not applicable for this indicator. One of five community counseling files reviewed was one day late per policy requirement.
At, 60 Days, following plan initiation.	Exception	Five out of five residential files reviewed were not applicable for this indicator. One of five community counseling files reviewed was one day late per policy requirement.
At, 90 Days, following plan initiation.	Exception	Five out of five residential files reviewed were not applicable for this indicator. Three of five files reviewed required a 90 day review; two of the three were late.
For court ordered youth, every six (6) months thereafter, or more frequently as needed to reflect changes in progress, needs, or service delivery.	Not Applicable	Ten out of ten files reviewed were not applicable for this indicator, as none were court ordered.
Additional Comments: There are no additional comments for this indicator.		
3.8 - Youth Records		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.8		Yes
		The Program has a written policy and procedure that meets all of the requirements for the indicator, it is Policy #3.8 Youth Records; Revised 10/15/25; Last Reviewed 11/25/25 by CEO
All records are marked "confidential".	Compliance	All youth records were clearly marked "Confidential," ensuring proper identification and adherence to privacy requirements.
All records are kept in a secure room or locked in a file cabinet that is marked "confidential" and only accessible by staff.	Compliance	All records were stored securely in locked file cabinets or designated confidential rooms accessible only to authorized staff.
When in transport, all records are locked in an opaque container marked "confidential".	Compliance	When transported, all records were placed in locked, opaque containers marked "Confidential," maintaining privacy and data security.
All records are maintained in a neat and orderly manner.	Compliance	Records were consistently maintained in a neat, orderly, and professional manner, ensuring quick access and review readiness.

<p>SHELTER FILES</p> <ol style="list-style-type: none"> 1. Table of Contents that outlines documents in each section 2. Screening 3. Informed Consent 4. Photograph of the youth 5. Shelter Intake Form 6. Suicide Assessment (if needed) 7. NIRVANA Self Report (NSR) 8. NIRVANA full Assessment 9. Plan of Service 10. Chronological Notes 11. Medication Inventory Form 12. Approved contact list 13. Copies of referrals made (if needed) 14. Discharge summary once case is closed 	<p>Compliance</p>	<p>Each Shelter file contained all required documents, including a table of contents, screening forms, consent forms, youth photograph, intake documentation, NIRVANA assessments, Plan of Service, chronological notes, medication inventory, approved contact list, referral documentation, and discharge summary.</p>
<p>COMMUNITY COUNSELING FILES</p> <ol style="list-style-type: none"> 1. Table of Contents that outlines documents in each section 2. Screening 3. Informed Consent 4. Community Counseling Intake Form 5. Suicide Assessment (if needed) 6. NIRVANA full Assessment 7. Plan of Service 8. Chronological case notes 9. Copies of referrals made (if needed) 10. Discharge summary once the case is closed 	<p>Compliance</p>	<p>Each Community Counseling file included all required documents, including a table of contents, screening forms, informed consent, intake documentation, NIRVANA assessment, Plan of Service, chronological notes, referrals, and discharge summary.</p>
<p>If records are kept electronically, the records are maintained securely and can be made immediately available upon request for audit purposes.</p>	<p>Compliance</p>	<p>Electronic records were securely maintained within password-protected systems with access limited to authorized personnel and were readily available upon request for audit purposes.</p>
<p>Records are retained for five years after the termination date of the contract that is funding the youth's service.</p>	<p>Compliance</p>	<p>Records were retained in compliance with policy for a minimum of five years following the termination date of the contract funding the youth's services.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		

3.10 - Discharge and Follow Up		Satisfactory with Exception(s)
Provider has a written policy and procedure that meets the requirement for Indicator 3.10		Yes
		The program has a policy, 3.10/Discharge and Follow-Up, that meets all requirements of the indicator. The policy was last revised on 10/15/25 and reviewed on 11/25/25 by CEO.
30 day follow-ups are provided post discharge for all youth served.	Compliance	Follow-up contacts were completed within 30 days post-discharge, with documentation confirming continued client stability and connection to recommended services.
60 day follow-ups are provided post discharge for all youth served.	Compliance	Follow-up contacts were also completed within 60 days post-discharge, ensuring ongoing support and successful transition for youth and families.
Each file contains a discharge summary that describes the reason for termination.	Compliance	Discharge summaries clearly described the reason for termination, confirming appropriate closure of services and alignment with client progress.
Each file contains a discharge summary that outlines the events of the case, services provided, progress of the youth and family, and recommendations for future treatment or services.	Compliance	Each discharge summary outlined key case events, services provided, and measurable progress made by the youth and family throughout service delivery.
Each file contains a discharge summary that describes the living arrangements of the child at termination. If the child is not returned to the family at termination, the discharge summary must contain the reasons for the alternative placement, plans for the child's living arrangement, and interim objectives set that will accomplish an eventual return, if possible and when appropriate.	Exception	Two out of five residential files reviewed did not describe living arrangements at discharge, only identified who the youth was being released to. One out of five residential files reviewed and three out of five community counseling files reviewed did have living arrangements at termination described. Two out of five residential files reviewed and two out of five community counseling files reviewed were not applicable, as the case is still open.
Each file contains a discharge summary that outlines the aftercare recommendations and the arrangements for case follow-up.	Compliance	Discharge summaries detailed aftercare recommendations and follow-up arrangements, ensuring continuity of care and resource connection beyond program exit.
Each file contains a NIRVANA Post Assessment.	Compliance	Each file contained a completed NIRVANA Post-Assessment, documenting the youth's progress and outcomes at discharge.

<p>For cases that are referred for services by Truancy Court for FINS services, or to the case staffing committee for consideration of a CINS petition as a result of truancy related issues; youth having been deemed Truant by the Court, the Provider shall verify school attendance during 30- and 60-day follow-ups if the youth remains subject to compulsory education. If verification cannot be obtained, efforts are documented in the youth’s file.</p>	<p>Not Applicable</p>	<p>Ten out of ten files reviewed were not applicable for this indicator, as none were referred for services by Truancy Court of FINS services, or the case staffing committee for consideration of a CINS petition as a result of truancy related issues.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>Domain Four</p>		
<p>4.0 - SNAP® Under 12</p>		<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 4.0</p>	<p>Yes</p>	
	<p>4.0 Snap Under 12 was reviewed and signed by CEO on 11/25/2025.</p>	
<p>A total of four SNAP® Under 12 file(s) were reviewed during this evaluation period. Of these, two were open and two were closed.</p>		
<p>Youth are screened to determine eligibility of services using the Florida Network Youth Screening Form.</p>	<p>Compliance</p>	<p>Youth are screened for service eligibility using the Florida Network Youth Screening Form prior to initiation.</p>
<p>The following documentation is required BEFORE initiating SNAP® services and located within the Youth File:</p>		
<p>SNAP® Client File Checklist</p>	<p>Compliance</p>	<p>The SNAP® Client File Checklist is completed and on file before services begin.</p>
<p>Florida Network CINS/FINS Youth Screening Form</p>	<p>Compliance</p>	<p>The Florida Network CINS/FINS Youth Screening Form is present and completed prior to service initiation.</p>
<p>SNAP® Brief Intake Screening Checklist (BISC)</p>	<p>Compliance</p>	<p>The SNAP® Brief Intake Screening Checklist (BISC) is completed and filed before service initiation.</p>
<p>The file contains the Florida Network Community Counseling Intake Form</p>	<p>Compliance</p>	<p>The Florida Network Community Counseling Intake Form is included in the youth file prior to services.</p>
<p>The NIRVANA Assessment</p>	<p>Compliance</p>	<p>The NIRVANA® Assessment is completed and filed before services begin.</p>
<p>The Reinforcement Trap Cycle</p>	<p>Compliance</p>	<p>The Reinforcement Trap Cycle is completed and included in the youth file prior to services.</p>
<p>The SNAP® Parenting Goal Sheet</p>	<p>Compliance</p>	<p>The SNAP® Parenting Goal Sheet is completed and on file prior to services.</p>
<p>The Child Way To Go Goal Sheet</p>	<p>Compliance</p>	<p>The Child Way To Go Goal Sheet is completed and on file prior to services.</p>
<p>The SNAP Child Screening Interview</p>	<p>Compliance</p>	<p>The SNAP® Child Screening Interview is completed and documented before services begin.</p>
<p>Consent to Treatment and Participation in Research Form</p>	<p>Compliance</p>	<p>Consent to Treatment and Participation in Research is signed and on file prior to service initiation.</p>
<p>Tool of Parenting Self-Efficacy (TOPSE) – pre-assessment</p>	<p>Compliance</p>	<p>The Tool of Parenting Self-Efficacy (TOPSE) pre-assessment is completed and filed prior to services.</p>

Child Behavior Checklist (CBCL) – caregiver	Compliance	The Child Behavior Checklist (CBCL) caregiver form is completed and filed prior to services.
Session Preparation and Delivery Activities		
Staff conduct weekly check-in calls with youth and caregivers.	Compliance	Staff complete and document weekly check-in calls with youth and caregivers as scheduled.
Weekly attendance is documented for youth.	Compliance	Weekly youth attendance is documented on the Youth Attendance Chart.
Weekly attendance is documented for caregiver.	Compliance	Weekly caregiver attendance is documented on the Caregiver Attendance Chart.
Weekly attendance is documented for siblings.	Compliance	Weekly sibling attendance is documented on the Sibling Attendance Chart.
If needed, make-up sessions and the Adherence Contact Notes are completed.	Compliance	Make-up sessions and Adherence Contact Notes are completed and documented when needed.
Each GROUP CYCLE MUST include the following documentation:		
SNAP® Pre-brief Checklist	Compliance	The SNAP® Pre-brief Checklist is completed for each group cycle.
Weekly Feedback Questionnaires	Compliance	Weekly Feedback Questionnaires are completed and filed for each session.
Weekly Youth Evaluation Forms	Compliance	Weekly Youth Evaluation Forms are completed and filed.
Weekly Caregiver Evaluation Forms	Compliance	Weekly Caregiver Evaluation Forms are completed and filed.
SNAP® Debrief Checklist completed after each session and uploaded within three (3) business days	Compliance	The SNAP® Debrief Checklist is completed after each session and uploaded within three (3) business days.
Discharge and Post-Assessment Documents & Required Discharge Documentation includes:		
SNAP® Group Evaluation Forms (Week 13 – youth and caregiver)	Compliance	Week 13 SNAP® Group Evaluation Forms (youth and caregiver) are completed and filed.
Post-TOPSE entered into NetMIS (in file from NetMIS)	Compliance	Post-TOPSE results are entered into NetMIS and filed from NetMIS.
Post Child Behavior Checklist (CBCL) – (entered into ASEBA-Web in Youth File)	Compliance	Post-CBCL results are entered into ASEBA-Web and filed in the youth record.
Post-NIRVANA entered into NetMIS (youth file from NetMIS)	Compliance	Post-NIRVANA results are entered into NetMIS and filed from NetMIS.
Discharge and Post-Assessment Documents & Required Discharge Documentation includes:		
Discharges are completed within 30 days of group completion	Compliance	Discharges are completed within thirty (30) days of group completion.
If a post-assessment is not completed, there are at least three (3) DOCUMENTED attempts to collect each post-assessment.	Not Applicable	The post assessment attempts are not found in 1 applicable case.
SNAP® Discharge Report is filed	Compliance	The SNAP® Discharge Report is completed and filed.
SNAP Discharge Report includes: Reason for discharge	Compliance	The discharge report includes the reason for discharge.
Summary of services delivered and goal progress	Compliance	The discharge report summarizes services delivered and progress toward goals.
Pre/post assessment outcomes (if available)	Compliance	The discharge report summarizes pre/post assessment outcomes when available.
Aftercare referrals or follow-up recommendations	Compliance	The discharge report documents aftercare referrals and follow-up recommendations.

Discharge and Post-Assessment Documents & Required Discharge Documentation includes:		
30-day and 60-day follow-ups were completed using the SNAP® Contact Note format.	Compliance	30-day and 60-day post-discharge follow-ups are completed using the SNAP® Contact Note format.
Follow-up records were entered into NetMIS within three (3) business days of completion.	Compliance	Follow-up records are entered into NetMIS within three (3) business days of completion.
Additional Comments: There are no additional comments for this indicator.		
4.1 - SNAP® Fidelity Monitoring		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.1		Yes
		4.1 Snap Fidelity Monitoring approved and signed by CEO on 11/25/2025.
Additional Comments: There are no additional comments for this indicator.		
4.2 - SNAP® for Youth		Not Applicable
Provider has a written policy and procedure that meets the requirement for Indicator 4.2		Yes
		Not Applicable - The agency does not have SNAP for Youth
A total of zero SNAP® for Youth file(s) were reviewed during this evaluation period. Of these, zero were open and zero were closed.		
Intake Documents Include the following (Before youth begins SNAP® group participation):		
SNAP® Youth Client File Checklist	Not Applicable	The program reported that it has other SNAP programs, but does not have SNAP For Youth program.
Florida Network Youth Screening Form	Not Applicable	The program reported that it has other SNAP programs, but does not have SNAP For Youth program.
Florida Network Community Counseling Intake Form	Not Applicable	The program reported that it has other SNAP programs, but does not have SNAP For Youth program.
SNAP Youth Intake Brief Screening Checklist (Teacher or Caregiver version)	Not Applicable	The program reported that it has other SNAP programs, but does not have SNAP For Youth program.
NIRVANA® Assessment	Not Applicable	The program reported that it has other SNAP programs, but does not have SNAP For Youth program.
Consent to Treatment and Participation in Research Form	Not Applicable	The program reported that it has other SNAP programs, but does not have SNAP For Youth program.
SNAP® for Youth Orientation Document	Not Applicable	The program reported that it has other SNAP programs, but does not have SNAP For Youth program.
Youth Goal Sheet	Not Applicable	The program reported that it has other SNAP programs, but does not have SNAP For Youth program.
How I Think Questionnaire (HIT)	Not Applicable	The program reported that it has other SNAP programs, but does not have SNAP For Youth program.

Social Skills Improvement System (SSIS) – Student Form	Not Applicable	The program reported that it has other SNAP programs, but does not have SNAP For Youth program.
Social Skills Improvement System (SSIS) – Teacher/Adult Form	Not Applicable	The program reported that it has other SNAP programs, but does not have SNAP For Youth program.
Intake Data Entry Compliance: All NetMIS data entries related to intake must be completed within three (3) business days.	Not Applicable	The program reported that it has other SNAP programs, but does not have SNAP For Youth program.
Weekly Group Compliance: Staff must conduct a check-in call with each youth using the SNAP® Client Group Reminder Log.	Not Applicable	The program reported that it has other SNAP programs, but does not have SNAP For Youth program.
During Sessions: Record weekly attendance in the Youth Attendance Log.	Not Applicable	The program reported that it has other SNAP programs, but does not have SNAP For Youth program.
For Make-up Sessions: Client Contact Note (minimum 45 min) and Fidelity Adherence Checklist are completed.	Not Applicable	The program reported that it has other SNAP programs, but does not have SNAP For Youth program.
For Make-up Sessions: Client Contact Note and Fidelity Adherence Checklist are uploaded and entered into NetMIS within three (3) business days of the make-up date (NetMIS).	Not Applicable	The program reported that it has other SNAP programs, but does not have SNAP For Youth program.
Post-Discharge Follow-up		
The 30-day Post-Discharge NETMIS Follow-up was completed as required.	Not Applicable	The program reported that it has other SNAP programs, but does not have SNAP For Youth program.
The 60-day Post-Discharge NETMIS Follow-up was completed as required.	Not Applicable	The program reported that it has other SNAP programs, but does not have SNAP For Youth program.
Follow-ups are documented using the SNAP Contact Note.	Not Applicable	The program reported that it has other SNAP programs, but does not have SNAP For Youth program.
The 30-day follow-up is entered into NetMIS within three (3) business days of each follow-up completion.	Not Applicable	The program reported that it has other SNAP programs, but does not have SNAP For Youth program.
The 60-day follow-up is entered into NetMIS within three (3) business days of each follow-up completion.	Not Applicable	The program reported that it has other SNAP programs, but does not have SNAP For Youth program.
Additional Comments: There are no additional comments for this indicator.		

4.3 - SNAP® Youth Justice		Satisfactory
		Yes
Provider has a written policy and procedure that meets the requirement for Indicator 4.3		4.3 Snap Youth Justice approved and signed by the CEO on 11/25/2025.
A total of four SNAP® Youth Justice (12-19) file(s) were reviewed during this evaluation period. Of these, two were open and two were closed.		
Pre-Service Documentation, prior to beginning group services, must be in youth files and includes:		
SNAP® Youth Client File Checklist	Compliance	All required SNAP® Youth Client File Checklists were completed prior to service initiation.
Florida Network Youth Screening Form	Compliance	All required Florida Network Youth Screening Forms were completed prior to service initiation.
Florida Network Community Counseling Intake Form	Compliance	Florida Network Community Counseling Intake Forms were properly documented prior to beginning group services.
NIRVANA® Assessment	Compliance	NIRVANA® Assessments were completed promptly and filed prior to service initiation.
Consent to Treatment and Participation in Research Form	Compliance	Consent to Treatment and Participation in Research Forms were signed and dated before youth participation.
SNAP® Orientation Document	Compliance	SNAP® Orientation Documents were completed and included in the file before the first session.
Youth Goal Sheet	Compliance	Youth Goal Sheets were developed collaboratively and finalized prior to service delivery.
How I Think Questionnaire (HIT)	Compliance	How I Think Questionnaires (HIT) were administered within the required pre-service timeframe.
Social Skills Improvement System (SSIS) – Student Form	Compliance	Social Skills Improvement System (SSIS) – Student Forms were completed prior to program participation.
Social Skills Improvement System (SSIS) – Teacher/Adult Form	Compliance	Social Skills Improvement System (SSIS) – Teacher/Adult Forms were obtained within the required timeframe.
All NetMIS data entries related to intake must be completed within three (3) business days.	Compliance	All NetMIS intake data entries were completed within the required three (3) business days.
Group Delivery and Fidelity: A check-in call is conducted 24-72 hours prior to each session and documented.	Compliance	Pre-session check-in calls were completed and documented 24–72 hours prior to each session.
Group Delivery and Fidelity: There is evidence that the youth attended a total of thirteen (13) sessions.	Compliance	Youth successfully participated in the full thirteen (13) SNAP® sessions as scheduled.

Post-Session & Evaluation Activities: Weekly group attendance and any issues are reported to each youth's JPO and the local CPO via email correspondence.	Compliance	Weekly group attendance and relevant updates were consistently reported to each youth's JPO and local CPO via email.
Post-Session & Evaluation Activities: Attendance Logs are maintained for each session.	Compliance	Attendance logs were accurately maintained and available for all program sessions.
Discharge Requirements		
Discharge summary completed for youth, regardless of completion status.	Compliance	Discharge summaries were completed for all youth, regardless of program completion status.
NIRVANA completed at Discharge	Compliance	NIRVANA® assessments were completed at discharge and filed appropriately.
At least three (3) documented attempts must be made to collect post-assessment data.	Compliance	At least three (3) documented attempts were made to collect post-assessment data prior to case closure.
Discharge Report Includes the Following:		
Reason for discharge	Compliance	Each discharge report clearly identifies the youth's reason for discharge.
Summary of services and goal progress	Compliance	Discharge reports include a comprehensive summary of services provided and progress toward goals.
Summary of pre/post test changes, if available	Compliance	Pre- and post-test results are summarized in the discharge report when available.
Aftercare recommendations or referrals	Compliance	Aftercare recommendations and referrals are documented to support ongoing success.
Post-Discharge Follow-Up Includes the following:		
The 30-day Post-Discharge Follow-up was completed.	Not Applicable	One out of four files applicable files reviewed. Youth was discharged from the program due to violation of probation. The youth was taken into custody and placed in detention program. DJJ requested for the discharge of youth from the program.
The 60-day Post-Discharge Follow-up was completed.	Not Applicable	No youth were applicable for review for this requirement.
Follow-ups are documented using the SNAP Contact Note Format.	Not Applicable	No youth were applicable for review for this requirement.
30-day follow-up is entered into NetMIS within three (3) business days of each follow-up completion.	Not Applicable	No youth were applicable for review for this requirement.
60-day follow-up is entered into NetMIS within three (3) business days of each follow-up completion.	Not Applicable	No youth were applicable for review for this requirement.
Additional Comments: There are no additional comments for this indicator.		

4.5 - SNAP® for Schools and Communities		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.5		Yes
		4.4 SNAP for Schools and Communities approved and signed by the CEO on 11/25/2025.
There is evidence the Measure of Classroom Environment (MoCE)-Pre-session is completed before beginning SNAP® for Schools and Communities.	Compliance	The Measure of Classroom Environment (MoCE) pre-session assessment is completed prior to beginning the SNAP® for Schools and Communities program.
A Fidelity Adherence Checklist completed per classroom was verified in the file.	Compliance	A Fidelity Adherence Checklist is completed for each classroom and verified in the file as required.
Each group session is entered into NetMIS within 3 business days of the session.	Compliance	Each group session is entered into NetMIS within three (3) business days of completion.
There is evidence of the SNAP® for Schools & Communities Feedback Form completed by the supervisory adult responsible at the final group.	Compliance	The SNAP® for Schools and Communities Feedback Form is completed by the supervising adult responsible at the final group session.
<i>Additional Comments: There are no additional comments for this indicator.</i>		
Domain Five		
5.0 - Shelter Program Services		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 5.0		Yes
		The agency has a policy titled 5.0 Shelter Program Services. The policy was revised on 10/15/2025 and signed by the CEO on 11/23/2025.
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.	Compliance	Youth are engaged in meaningful, structured activities seven days a week during awake hours, minimizing idle time and promoting positive development.
At minimum one hour of physical activity is provided daily.	Compliance	A minimum of one hour of physical activity is provided to youth each day as part of the daily schedule.
Youth are provided the opportunity to participate in a variety of faith-based activities aligned with their preference or spiritual beliefs. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities.	Compliance	Youth are offered opportunities to participate in faith-based activities aligned with their personal beliefs, and non-punitive structured activities are provided for those who choose not to participate.

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.	Compliance	Daily programming includes scheduled time for homework completion, access to age-appropriate reading materials, and opportunities for quiet reading and learning.
Daily programming schedule is publicly posted and accessible to both staff and youth.	Compliance	The daily programming schedule is clearly posted in a public area and accessible to both staff and youth.
Psychoeducational Groups are conducted a minimum of five days per week using a structured group process model. There is a clear group leader or facilitator identified, and documentation includes the date/time of group, list of participants, length of group, and the topic.	Compliance	Psychoeducational groups are conducted a minimum of five days per week and follow a structured group process model. Each group has a clearly identified leader or facilitator. Group documentation is complete and consistently includes the date and time of the session, length of the group, topic addressed, and a list of participants.
Formal and accessible grievance procedures for youth, including available grievance forms and a locked box, are accessible to youth in a common area.	Compliance	Formal and accessible grievance procedures are in place for youth, including the availability of grievance forms and a locked grievance box located in a common area.
Grievance boxes are checked at least once daily, excluding weekends and holidays) by a member of management or a designated supervisor. Each check is logged in the program’s daily logbook, including the date, time, and name of the person conducting the check.	Exception	A review of the logbook was conducted. A search for the period of January 7-29, 2026, revealed no documentation indicating that the supervisor or program director checked the grievance box.
Only the Program Director/Supervisor has access to and manages grievances unless it is toward themselves (which is escalated to higher leadership).	Compliance	Only the Program Director or Supervisor has access to and manages submitted grievances, unless the grievance concerns them, in which case it is escalated to higher leadership.
All grievances are resolved and documented by the Program Director within 72 hours. If this does NOT occur within the 72-hour period, there is sufficient documentation explaining the cause of the delay in resolution.	Compliance	All grievances are reviewed, resolved, and documented by the Program Director within 72 hours, with documentation provided for any delays beyond that timeframe.
Grievances are maintained on file for a minimum of one (1) year.	Compliance	Grievances are securely maintained on file for a minimum of one (1) year in accordance with program policy.
Additional Comments: There are no additional comments for this indicator.		
5.1 Shelter Environment		Satisfactory with Exception(s)
Provider has a written policy and procedure that meets the requirement for Indicator 5.1		Yes
		The agency has a policy titled 5.1 Shelter Services. The policy was revised on 10/15/2025 and signed by the CEO of 11/23/2025.
The facility is clean, neat, and well-maintained.	Compliance	The facility is consistently clean, neat, and well-maintained throughout all areas.

Furnishings shall be in good repair and maintained as needed.	Compliance	All furnishings are in good repair and suitable for use.
The program is free of insect infestation.	Compliance	The facility remains free of any insect infestation.
All bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, mildew and in good working order.	Compliance	Bathrooms and shower areas are clean, fully functional, odor-free, and maintained to high sanitary standards.
There is no graffiti on walls, doors, or windows.	Compliance	No graffiti or defacement is present on any walls, doors, or windows.
Lighting is adequate for tasks performed there.	Compliance	Lighting is sufficient and appropriate for all activities and workspaces.
Exterior areas are free of debris.	Compliance	Exterior areas are clear of debris and well-kept.
Grounds are free of hazards.	Compliance	Grounds are regularly inspected and free of hazards.
Dumpster and garbage can(s) are covered.	Compliance	Dumpsters and garbage cans are securely covered and properly maintained.
All doors are secure.	Compliance	All facility doors are secure and functioning properly.
In and out access is limited to staff members and key control is in compliance.	Compliance	Access to and from the facility is restricted to authorized staff, and key control procedures are followed in compliance with policy.
All agency and staff vehicles are locked. All agency vehicles are equipped with major safety equipment including first aid kit (with current, non-expired items that are replaced regularly), a fire extinguisher, a flashlight, a glass breaker, and seat belt cutter.	Compliance	All agency and staff vehicles remain locked when not in use and are equipped with required safety gear, including a stocked first-aid kit, fire extinguisher, flashlight, glass breaker, and seatbelt cutter.
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.	Compliance	Required postings—including evacuation maps, client rules, grievance procedures, abuse hotline numbers, and DJJ incident reporting information—are clearly displayed and accessible.
Agency has a current DCF Child Care License which is displayed in the facility.	Compliance	The current DCF Child Care License is valid and visibly posted in the facility.
Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects (e.g. cords, rope, metal shower rings).	Exception	The lids were not on two of the laundry soap bottles during the initial tour of the shelter. During the shelter tour, mini blinds with cords to open and close blinds were observed in some resident sleeping areas. Both observations were reported to the agency to be addressed as they were identified as potential hazards.

<p>All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely. A perpetual inventory is the primary means of maintaining a current and real-time inventory. The weekly inventory is 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>Compliance</p>	<p>All chemicals are properly listed, approved, stored securely, and inventoried both perpetually and through weekly verification; inventories are accurate and current across all storage areas.</p>
<p>Material Safety Data Sheets (MSDS) are maintained on each chemical item.</p>	<p>Compliance</p>	<p>Material Safety Data Sheets (MSDS) are maintained and accessible for every approved chemical.</p>
<p>Washer/dryer are operational & general area/lint collectors are cleaned after ever load.</p>	<p>Exception</p>	<p>All three dryers contained lint, creating a potentially hazardous situation. Also, there was a broken object with a nail attached on top of the dryer during the tour. Both observations were reported to the agency to be removed as they were identified as potential hazards.</p>
<p>Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket.</p>	<p>Compliance</p>	<p>Each youth is provided with an individual bed, clean mattress, pillow, and sufficient linens and blankets.</p>
<p>Youth have a safe, lockable place to keep personal belongings, if requested.</p>	<p>Compliance</p>	<p>Youth have access to a secure, lockable space for personal belongings upon request.</p>
<p>Fire Safety and Health Hazards</p>		
<p>An annual facility fire inspection was conducted, and the facility is in compliance with the local fire marshal and fire safety code within the jurisdiction.</p>	<p>Compliance</p>	<p>The annual fire inspection has been completed, and the facility meets all fire marshal and local code requirements.</p>
<p>Agency completes at least one fire drill on each shift monthly and demonstrates they are within 2 minutes or less.</p>	<p>Exception</p>	<p>As applicable 3rd Shift: After reviewing the fire drill documents, fire drills were conducted from January through September. However, it appears that the drills for October, both the 2nd shift and overnight shift were not completed. Additionally, there are no records for November and December 2025.</p>
<p>Completes 1 mock emergency drill per shift quarterly, at a minimum.</p>	<p>Exception</p>	<p>As applicable 3rd Shift: After reviewing mock drills documentation provided, these drills were conducted from January through September. However, it appears that the drills for October, both the 2nd shift and overnight, were not completed. Additionally, there are no records for November and December 2025.</p>

<p>All annual fire safety equipment inspections are valid and up-to-date (building extinguishers, sprinklers, alarm systems, kitchen overhead hood, and fire extinguishers in all vehicles). Fire extinguishers are easily accessible in the event of an emergency and not locked away.</p>	<p>Compliance</p>	<p>All fire safety equipment, including extinguishers, sprinklers, alarms, kitchen hood systems, and vehicle extinguishers, has current inspection tags and is easily accessible in case of emergency.</p>
<p>The agency has a current Satisfactory Residential Group Care inspection report from the Department of Health.</p>	<p>Compliance</p>	<p>The facility maintains a current, satisfactory Residential Group Care inspection report from the Department of Health.</p>
<p>The agency has a current Satisfactory Food Service inspection report from the Department of Health, and food menus are posted, current and signed by a Licensed Dietitian annually.</p>	<p>Compliance</p>	<p>The program holds a valid, satisfactory Food Service inspection report from the Department of Health; menus are current, posted, and signed annually by a Licensed Dietitian.</p>
<p>All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored. Packages in the pantry area are dated upon opening.</p>	<p>Compliance</p>	<p>Cold and dry food items are properly labeled, dated, and stored; pantry and storage areas are clean and organized.</p>
<p>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>Compliance</p>	<p>Refrigerators and freezers are clean, maintain required temperatures, and all appliances are operational and sanitary.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>5.2 - Shelter Search Policy</p>		<p>Satisfactory with Exception(s)</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 5.2</p>		<p>Yes</p>
		<p>The agency has a policy titled 5.2 Shelter Search Policy. The policy was revised on 10/15/2025 and signed by the CEO of 11/23/2025.</p>
<p>Each youth is searched via a fully charged, hand-held metal detector wand from head to toe, back to front, each time they return to the shelter.</p>	<p>Compliance</p>	<p>Each youth is searched thoroughly using a fully charged hand-held metal detector wand from head to toe and back to front upon every return to the shelter, as observed during the review.</p>
<p>Shelter staff conduct searches of outdoor recreational areas prior to youth using the area.</p>	<p>Exception</p>	<p>An interview with the program supervisor was conducted. The supervisor reported that the program has not been conducting searches of the recreation area, which includes the basketball court, before the youth head to the designated recreational areas.</p>

Shelter staff conduct frequent and random searches on each shift.	Compliance	Shelter staff perform frequent and random searches during each shift to maintain a secure and controlled environment.
Additional Comments: There are no additional comments for this indicator.		
5.3 - Logbook Requirements		Limited
Provider has a written policy and procedure that meets the requirement for Indicator 5.3		Yes The agency has a policy titled 5.3 Logbooks. The policy was revised on 10/15/2025 and signed by the CEO of 11/23/2025.
Data sources Reviewed	Dates Reviewed	Logbook Format
Agency logbooks over last six months.	Jan 7th, Jan 15th, Dec 23rd, Jan 16th, Nov 24th, 12/23/2025, 1/7/2026, 1/15/2026	Paper Log
The program has a process in place to document daily activities, events, and other major occurrences.	Compliance	The program maintains a consistent process to document daily activities, events, and major occurrences.
Safety and security issues that could impact the youth and/or program are highlighted.	Compliance	Safety and security issues that may impact the youth and/or program are clearly identified and highlighted.
All entries are brief and legibly written in ink for paper logbooks.	Compliance	All logbook entries are concise and legibly written in ink.
All entries include: a. Time of incident/activity/event b. Names of youth and staff involved c. Brief statement providing pertinent information d. Signature of person making the entry	Compliance	All entries include the time of the incident or activity, names of youth and staff involved, a brief statement of pertinent information, and the signature of the person making the entry.
All recording errors are struck through with a clear line with staff initial and date.	Exception	A total of eight samples were reviewed. Eight out of eight logged entries reviewed did not correctly perform documenting void, strike through, staff initials and date.
The use of white-out is prohibited and all entries are made in ink with no erasures or white out areas for paper logbooks.	Compliance	White-out is not used, and all entries are made in ink with no erasures or alterations.

<p>At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry to become aware of any unusual occurrences, problems, etc. and makes an entry signed and dated into the log book indicating the dates reviewed to document the review.</p>	<p>Exception</p>	<p>After searching through the logbooks, it was found that the entries lack consistency in having supervisors or counselors reviewing and dating the logbooks. A total of eight entries were reviewed. Eight out of eight entries reviewed did not correctly perform documenting reviews at the beginning of shift since last entry. Agency is not making entries into logbook that capture supervisor and counselor dates in which they have documented dates reviewed in the logbook.</p>
<p>All direct care staff reviews the logbook at the beginning of each shift for the previous two shifts (at minimum) and include the dates reviewed, which is evidenced by the date and their signature at time of entry.</p>	<p>Exception</p>	<p>Staff did not consistently document that they reviewed the logbooks before starting their shifts.</p>
<p>Program director or designee reviews the facility logbook(s) every week and makes a note chronologically indicating dates reviewed and if any corrections, recommendations and follow-up is required, which is evidenced by the date and their signature at time of entry.</p>	<p>Exception</p>	<p>An interview with the residential supervisor was conducted. She reported that while the supervisor does write the necessary information on the shift change document, it is not always documented in the program logbook.</p>
<p>Supervision and resident counts are documented.</p>	<p>Compliance</p>	<p>Supervision and resident counts are consistently documented.</p>
<p>Visitation and home visits are documented.</p>	<p>Exception</p>	<p>A review of the program logbook was conducted, no entries were found related to proper documentation of home visits. There were no indication that the youth were on specific home visits. Some entries mentioned off-site activities, but there were no actual records of home visits.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>5.4 - Staffing Standards and Enhanced Supervision</p>		<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 5.4</p>		<p>Yes</p>
		<p>Agency has a policy titled 5.4 . Policy was approved and signed by the CEO 11/25/2025</p>
<p>Program maintains minimum staffing ratios as required by Florida Administrative Code and contract. 1 staff to 6 youth during awake hours and 1 to 5 youth during offsite activities.</p>	<p>Compliance</p>	<p>The program maintains required staffing ratios in accordance with Florida Administrative Code and contract standards, ensuring a minimum of one staff to six youth during awake hours and one staff to five youth during offsite activities.</p>

<p>All shifts consistently maintain a minimum of two (2) staff present. Program staff included in the staff-to-youth ratio includes staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff.</p>	<p>Compliance</p>	<p>All shifts consistently maintain a minimum of two staff members on duty, with staff included in the ratio verified as background-screened and properly trained youth care, supervision, or treatment personnel.</p>
<p>The shelter has implemented policies and procedures to ensure youth safety when being supervised by staff of the opposite sex.</p>	<p>Compliance</p>	<p>The shelter has implemented and follows clear policies and procedures to ensure youth safety when supervised by staff of the opposite sex.</p>
<p>The program staff schedule is provided to staff or posted in a place visible to staff.</p>	<p>Compliance</p>	<p>Staff schedules are provided and/or posted in a visible location to ensure adequate coverage and awareness of staffing assignments.</p>
<p>There is a holdover overtime rotation roster that includes home telephone numbers of staff who may be available when additional coverage is needed.</p>	<p>Compliance</p>	<p>A holdover and overtime rotation roster is maintained and includes contact information for staff available to provide additional coverage as needed.</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. Times are documented in real time. (The times do not supersede requirements for constant supervision of youth at risk of suicide.)</p>	<p>Compliance</p>	<p>Staff observe youth at least every fifteen (15) minutes while in sleeping rooms, including during sleep periods, illness, or room restriction, with all checks documented in real time.</p>
<p>The program assigns specific staff during each shift to monitor the location, behavior, and movement of youth on enhanced supervision. The assignment of staff to youth on enhanced supervision status is documented in the shelter log and staff calendar.</p>	<p>Not Applicable</p>	<p>There were no youth on close watch supervision, however, after reviewing the log books staff members are informed every shift if a youth is on close watch supervision. The agency is also</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>5.5 - Behavior Management Strategies</p>		<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 5.5</p>		<p>Yes</p>
		<p>The agency has a policy titled 5.5 Behavior Management Strategies. The policy was revised on 10/15/2025 and signed by the CEO of 11/23/2025.</p>
<p>A Behavior Management Strategy (BMS) is in place:</p>		

The program has a detailed written description of the BMS and it is explained during program orientation.	Compliance	The program maintains a detailed written description of its Behavior Management Strategy (BMS), which is reviewed with youth during program orientation.
The written description of the behavioral management strategies include:		
A wide variety of positive incentives are used by the program.	Compliance	The written BMS outlines a wide variety of positive incentives used by the program to encourage appropriate behavior.
Appropriate interventions are used by the program to teach youth new behaviors and help youth understand the natural consequences for their actions.	Compliance	The BMS includes appropriate interventions designed to teach youth new skills and help them understand natural consequences for their actions.
Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior.	Compliance	Behavioral interventions are applied immediately, consistently, and proportionate to the severity of the behavior.
The Behavior Management Strategy includes:		
Consequences for violation of program rules are applied logically and consistently.	Compliance	Consequences for violations of program rules are applied logically, consistently, and fairly across all youth.
Program uses a variety of rewards/incentives to encourage participation and completion of the program.	Compliance	The program uses a variety of rewards and incentives to promote participation, engagement, and program completion.
All staff are trained in the theory and practice of administering BMS rewards and consequences.	Compliance	All staff are trained in both the theory and practical application of administering BMS rewards and consequences.
Supervisors are trained to monitor the use of behavioral interventions by their staff to include the use of point-based and level-based interventions, if applicable to the program intervention strategies.	Compliance	Supervisors are trained to monitor staff implementation of behavioral interventions, including point- or level-based systems when applicable.
There is a protocol for providing feedback and evaluation of staff regarding their use of the positive and negative consequences.	Compliance	The program has a clear protocol for providing feedback and evaluation to staff regarding their use of positive and negative consequences.
In general, BMS promotes order, safety, security, respect, fairness, and protection of resident rights.	Compliance	The BMS promotes order, safety, security, respect, fairness, and protection of youth rights throughout the program environment.
BMS provides constructive discipline that encourages youth to meet behavior expectations.	Compliance	The BMS provides constructive discipline that encourages youth to meet and maintain behavioral expectations.

BMS provides for positive reinforcement & recognition; constructive dialogue & peaceful resolution; and minimizes separation of youth from the general population.	Compliance	The BMS emphasizes positive reinforcement, recognition, constructive dialogue, and peaceful conflict resolution while minimizing unnecessary separation from peers.
Disciplinary measures do not deny the youth any of the following: regular meals and snacks, clothing, sleep, physical or mental health services, educational services, exercise, correspondence privileges, or contact with parents/guardians, attorney of record, juvenile probation officer or clergy.	Compliance	Disciplinary measures never deny youth access to meals, clothing, sleep, healthcare, education, exercise, communication privileges, or contact with parents/guardians, attorneys, probation officers, or clergy.
Additional Comments: There are no additional comments for this indicator.		
5.6 - Program Orientation		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 5.6	Yes	
	The agency has a policy titled 5.6 Program Orientation. The policy was revised on 10/15/2025 and signed by the CEO of 11/23/2025.	
A total of seven Program Orientation file(s) were reviewed during this evaluation period. Of these, two were open and five were closed.		
During the first 24 hours following admission, the program must begin the orientation process, to include:		
Youth received a comprehensive orientation and handbook provided within 24 hours.	Compliance	Youth receive a comprehensive orientation and handbook within the first 24 hours of admission in accordance with program policy.
Youth Orientation is discussed with the youth and includes the following:		
Youth are given a list of contraband items.	Compliance	Youth are provided with a list of contraband items and understand restrictions for safety and security.
Behavioral Expectations and a review of the BMS	Compliance	Behavioral expectations are reviewed in detail, including an explanation of the program’s Behavior Management Strategy (BMS).
Dress code explained	Compliance	The program’s dress code is explained to youth during orientation.
Review of access to medical and mental health services	Compliance	Youth are informed of available medical and mental health services and how to access them.
Procedures for visitation, mail and telephone	Compliance	Procedures for visitation, mail, and telephone use are reviewed with youth during orientation.
Grievance procedure	Compliance	The program’s grievance procedure is explained, including how to file a grievance and access grievance forms.
Disaster preparedness instructions	Compliance	Youth receive disaster preparedness instructions and understand emergency procedures.
Physical layout of the facility	Compliance	Youth are oriented to the physical layout of the facility, including key safety areas and exits.

Sleeping room assignment and introductions	Compliance	Sleeping room assignments are reviewed, and youth are introduced to peers and staff as part of the orientation process.
Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	Compliance	Youth receive suicide prevention information, including how to alert staff if they or others experience suicidal thoughts.
Review of program schedule	Compliance	The daily program schedule is reviewed with youth to promote understanding of structure and expectations.
Additional Comments: There are no additional comments for this indicator.		
5.7 - Youth Room Assignment		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 5.7		Yes
		The agency has a policy titled 5.7 Youth Room Assignment. The policy was revised on 10/15/2025 and signed by the CEO of 11/23/2025.
A total of seven Youth Room Assignment file(s) were reviewed during this evaluation period. Of these, two were open and five were closed.		
The program determines room assignments during admission and intake using the following indicators:		
Review of youth’s history, status & exposure to trauma	Compliance	Youth classification includes a thorough review of the youth’s history, current status, and exposure to trauma to ensure safe and appropriate placement.
Collateral contacts	Compliance	Staff make collateral contacts, as needed, to gather additional information relevant to youth classification and safety.
Initial interactions with and observations of the youth	Compliance	Initial interactions and staff observations of the youth are used to inform room assignments and supervision levels.
Separation of younger youth from older youth	Compliance	Younger youth are housed separately from older youth to promote safety and developmental appropriateness.
Separation of violent youth from non-violent youth	Compliance	Youth with a history of violent behavior are separated from non-violent youth to reduce risk and maintain safety.
Identification of youth susceptible to victimization	Compliance	Youth identified as susceptible to victimization are assigned rooms that promote protection and increased supervision.
Presence of medical, mental, or physical disabilities	Compliance	Youth with medical, mental health, or physical disabilities are appropriately classified to ensure their needs are safely accommodated.
Suicide risk	Compliance	Youth are screened for suicide risk upon admission, and any identified concerns are addressed immediately through safety planning and supervision.
Sexually aggressive and predatory behavior	Compliance	Youth exhibiting sexually aggressive or predatory behaviors are identified and separated to maintain the safety of others.
Acute health symptoms requiring quarantine or isolation	Compliance	Youth presenting acute health symptoms are appropriately quarantined or isolated in accordance with health and safety protocols.

An alert is immediately entered into the program’s alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors.	Compliance	Alerts are immediately entered into the program’s alert system for youth with special needs or risks, including suicide risk, mental health, substance abuse, medical, or security concerns.
Additional Comments: There are no additional comments for this indicator.		
5.8 - Video Surveillance		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 5.8	Yes	
	The agency has a policy titled 5.8 Video Surveillance system. The policy was revised on 10/15/2025 and signed by the CEO of 11/23/2025.	
The agency has a system in operation 24 hours a day, 7 days a week. Does it demonstrate:		
A written notice that is conspicuously posted on the premises for the purpose of security; *(for all staff, youth, and visitors, advising if the program has a surveillance system that records both audio and video, indicating consent to audio and video recording). *Effective 12/18/25	Compliance	A written notice indicating video surveillance for security purposes is conspicuously posted on the premises.
Cameras are in the 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 (including locations where youth searches are conducted).	Compliance	Cameras are positioned in key interior areas (e.g., intake office, counseling rooms, cafeteria, and dayroom) and exterior locations (e.g., entrances, exits, recreation areas, and parking lots) where youth, staff, and visitors congregate or pass through.
All cameras are visible.	Compliance	All cameras are clearly visible and serve as an effective deterrent to unsafe or prohibited behavior.
No cameras are placed in bathrooms or sleeping quarters.	Compliance	Cameras are not placed in bathrooms or sleeping quarters, ensuring the privacy and dignity of youth and staff.
The system can capture and retain video photographic images, which must be stored for a minimum of 30 days.	Compliance	The video surveillance system captures and retains recordings for a minimum of 30 days in compliance with program requirements.
The system can record date, time, location, and maintain a resolution that enables facial recognition.	Compliance	The system records date, time, and location, maintaining sufficient resolution to enable facial recognition when needed.
Cameras can operate during a power outage.	Compliance	Cameras and recording equipment remain operational during power outages, supported by backup systems.
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel).	Compliance	A current list of designated personnel authorized to access the surveillance system, including off-site access permissions, is maintained and up to date.

Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook. The reviews assess the activities of the facility and include a review of a random sample of overnight shifts.	Compliance	Supervisory review of surveillance footage is conducted at least once every 14 days, with review periods and findings documented in the facility logbook, including random samples of overnight shifts.
Requests for video recordings pursuant to investigations or quality improvement visits are provided within 24-72 hours of the request.	Compliance	The agency has a policy that video recordings requested for investigations or quality improvement purposes are provided within 24–72 hours of the request.
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. There is evidence that all efforts made to obtain repairs are documented and maintained.	Not Applicable	There was evidence provided by the chief compliance officer that a work order was placed on May 1, 2025, to reboot the camera system, however it does not show the date the malfunction happened.
Additional Comments: There are no additional comments for this indicator.		
Domain Six		
6.0 - Medication Management and Distribution		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 6.0		Yes
		The agency has a policy called 6.0 Medication. The policy was revised on 10/9/2025. The CEO reviewed and signed the policy on 2026.11/25/2025.
A total of four Medication Management and Distribution file(s) were reviewed during this evaluation period. Of these, four were open and zero were closed.		
The agency has an internal quality improvement process to ensure appropriate medication management and distribution methods to track medication errors and identify systemic issues and implement mitigation strategies, as appropriate.	Compliance	The agency maintains an active quality improvement process to monitor and enhance medication management and distribution practices, addressing errors and implementing mitigation strategies as needed.
All non-nursing shelter staff designated to assist with the self-administration of medication receive in-person medication administration training: a. provided by a Registered Nurse b. demonstrate competency c. maintain re-certification annually	Compliance	All non-nursing shelter staff designated to assist with self-administration of medications receive in-person training provided by a Registered Nurse, demonstrate competency, and maintain annual re-certification.

<p>There is evidence of, at least, quarterly staff meetings conducted by RN and/or Shelter Manager to:</p> <ul style="list-style-type: none"> a. review and assess strategies implemented to reduce medication errors shelter wide b. analyze factors that contributed to medication errors c. allow staff the opportunity to practice and role-play solutions 	<p>Compliance</p>	<p>Quarterly staff meetings led by the RN and/or Shelter Manager are conducted to review medication error trends, analyze contributing factors, and practice strategies for prevention through discussion and role-play.</p>
<p>Any (non-nursing) staff member responsible for assisting with the self-administration of medications is clearly identified and designated on the staff schedule and shift change report/shift responsibility form on each shift.</p>	<p>Compliance</p>	<p>Staff authorized to assist with medication distribution are clearly designated on the staff schedule and shift responsibility forms for every shift.</p>
<p>The program has strategies to ensure medications are provided within the time frame.</p>	<p>Compliance</p>	<p>The program has established procedures to ensure medications are administered within required timeframes.</p>
<p>The agency has a clear method of communicating which youth are on medications with the times and dosage easily discernible by all staff on each shift.</p>	<p>Compliance</p>	<p>A clear communication system is maintained to ensure staff on each shift can easily identify youth medication schedules, including times and dosages.</p>
<p>Any staff member deemed responsible for a medication error, received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. An RN from another Florida Network shelter may be engaged to provide the refresher training virtually if an RN is not currently on staff, with Florida Network approval.</p>	<p>Compliance</p>	<p>Staff responsible for a medication error receive refresher training from an RN and must demonstrate competency before resuming medication administration duties.</p>
<p>For any staff member deemed responsible for 3 errors within a 1-year time frame, their certification is suspended. Staff were ONLY recertified after completing a full in-person medication administration training, demonstrating competency and receiving certification from the RN.</p>	<p>Not Applicable</p>	<p>No staff have committed 3 errors within a year. This item is not applicable.</p>
<p>All medications (included narcotics and controlled medications) are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth.</p>	<p>Compliance</p>	<p>All medications, including controlled substances, are securely stored in a Pyxis ES Medication Cabinet that is inaccessible to youth.</p>

<p>Pyxis machine stored in accordance with guidelines in Florida Statute 499.0121 and policy section Medication Management. FS 499.0121 states the establishment where medications are stored must:</p> <ul style="list-style-type: none"> (a) Be of suitable size and construction to facilitate cleaning, maintenance, and proper operations; (b) Have storage areas designed to provide adequate lighting, ventilation, temperature, sanitation, humidity, space, equipment, and security conditions; (c) Have a quarantine area for storage of prescription drugs that are outdated, damaged, deteriorated, misbranded, or adulterated, or that are in immediate or sealed, secondary containers that have been opened; (d) Be maintained in a clean and orderly condition; and (e) Be free from infestation by insects, rodents, birds, or vermin of any kind. 	<p>Compliance</p>	<p>The Pyxis machine and medication storage area meet all conditions outlined in Florida Statute 499.0121, ensuring cleanliness, security, proper ventilation, temperature control, and pest-free conditions.</p>
<p>Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station.</p>	<p>Compliance</p>	<p>The agency maintains a minimum of two site-specific Pyxis ES System Managers to ensure continuous oversight and accountability.</p>
<p>Oral medications are stored separately from injectable or topical medications.</p>	<p>Compliance</p>	<p>Oral medications are stored separately from injectable and topical medications to prevent cross-contamination.</p>
<p>Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose.</p>	<p>Compliance</p>	<p>Medications requiring refrigeration are stored in a secure, designated refrigerator or within a secured room inaccessible to youth.</p>
<p>Temperature requirements are 2-8 degrees C or 36-46 degrees F for storage of medications.</p>	<p>Compliance</p>	<p>Medication refrigeration units are consistently maintained at 2–8°C (36–46°F) to meet temperature requirements.</p>
<p>Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics).</p>	<p>Compliance</p>	<p>Only authorized staff listed in User Permissions have access to secured medications, with restricted access to controlled substances.</p>
<p>Perpetual inventory with running balances are maintained for controlled substances.</p>	<p>Compliance</p>	<p>Controlled substances are tracked through a perpetual inventory system maintaining real-time running balances.</p>
<p>Shift-to-shift counts (verified by a witness and is documented) are conducted and documented for controlled substances.</p>	<p>Compliance</p>	<p>Shift-to-shift counts of controlled substances are conducted and documented by two staff members to ensure accuracy and accountability.</p>
<p>Non-controlled medication and over-the-counter medications that are accessed regularly are inventoried weekly.</p>	<p>Compliance</p>	<p>Regularly accessed non-controlled and over-the-counter medications are inventoried weekly to ensure proper tracking.</p>

Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly.	Compliance	Syringes and sharps are securely stored, counted, and documented on a weekly basis.
There are monthly reviews of Pyxis Reports to monitor medication management practice.	Compliance	Monthly Pyxis reports are reviewed to monitor medication management practices and identify any trends requiring corrective action.
Medication is verified using one of the three methods outlined in Policy 4.02: 1. Contact Pharmacy 2. Registered Nurse or Licensed Practical Nurse 3. Pill Identifier (Pill Finder) – Drugs.com	Compliance	Medications are verified using approved methods as outlined in Policy 4.02, including contact with the pharmacy, verification by registered or licensed nursing staff, or using a validated pill identifier site by the nurse or trained/certified staff.
When nurse is on duty, medication processes are always conducted by the nurse. If nurse or licensed healthcare staff is not onsite, then the designated staff who has been trained to assist in the self-administration of medication distribution by a licensed Registered Nurse is responsible to provide the medication.	Compliance	When a nurse is on duty, all medication administration processes are conducted by nursing staff; when unavailable, trained and certified staff perform distribution under established procedures.
The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy.	Compliance	The medication delivery process fully aligns with Florida Network’s Medication Management and Distribution Policy.
All discrepancies are cleared each shift.	Compliance	All medication discrepancies are identified, reviewed, and cleared at the end of each shift.
Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a) TOP COVER b) BACK PANEL- LEFT TALL CABINET LOCK- LEFT c) BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	Compliance	Pyxis system keys labeled “TOP COVER,” “BACK PANEL-LEFT,” and “BACK PANEL-RIGHT” are accessible to staff for emergency access in the event of a system malfunction, with all access appropriately documented.
A Medication Distribution Log is used for the distribution of medication by non-licensed and licensed staff.	Compliance	A Medication Distribution Log is consistently used by both licensed and non-licensed staff to record the administration of all medications.
The documentation includes the time of administration on the Medication Distribution log and evidence of both (youth and staff initials) that the dosage was given.	Compliance	Documentation on the Medication Distribution Log clearly reflects the time of administration and includes the initials of both the youth and the administering staff member as verification.
Staff shall assist youth with medications within one hour of the scheduled time of delivery as ordered by the medication. E.g. 0730 medication can be given between 0630 – 0830.	Compliance	The nurse or designated staff member distributes medications within one hour of the scheduled delivery time in accordance with medical orders, ensuring timely and accurate dosage.

<p>Upon admission to shelter services, the youth and parent or guardian (if available) shall be interviewed about the youth’s current medications as part of the Medical and Mental Health Assessment screening. This process will be conducted by a Registered Nurse if one is on premises. Otherwise, this interview will be conducted by on-duty staff and reviewed by the Registered Nurse within three (3) business days.</p>	<p>Compliance</p>	<p>Upon admission, youth and parents or guardians are interviewed regarding current medications as part of the Medical and Mental Health Assessment, conducted by the Registered Nurse or is reviewed by a Registered Nurse within three business days.</p>
<p>Upon intake/admission of a youth, an on-shift certified supervisor of higher level staff will review all medication forms on the next business day. In the event the agency does not have a Registered Nurse, the medication review will be conducted by a certified Leadership position.</p>	<p>Compliance</p>	<p>All medication forms are reviewed by a certified supervisor or leadership-level staff member on the next business day following youth intake, ensuring proper oversight and compliance with medication procedures.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>6.1 - Naloxone Administration and Opioid Overdose Response</p>		<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 6.1</p>		<p>Yes The agency has a policy titled 5.8 Video Surveillance system. The policy was revised on 10/15/2025 and signed by the CEO of 11/23/2025.</p>
<p>Naloxone is stored between 37 and 77 degrees F and is stored with a cold pack when transported in vehicles to maintain effectiveness.</p>	<p>Compliance</p>	<p>Naloxone is securely stored at appropriate temperatures between 37°F and 77°F, and cold packs are used during vehicle transport to ensure medication stability and effectiveness.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>6.2 - Suicide Prevention</p>		<p>Satisfactory with Exception(s)</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 6.2</p>		<p>Yes The program has a policy, 6.2/ Suicide Prevention, that meets all requirements of the indicator. The policy was last revised on 10/15/25 and reviewed on 11/25/25 by CEO.</p>
<p>Shelter maintains a written suicide prevention & response plan approved by the Florida</p>		<p>Yes</p>
<p>SNAP maintains a written suicide prevention & response plan approved by the Florida</p>		<p>Yes</p>
<p>Community Counseling maintains a written suicide prevention & response plan approved</p>		<p>Yes</p>
<p>Upon intake, every youth is screened for suicidality using the five Florida Network questions.</p>	<p>Compliance</p>	<p>All youth are consistently screened for suicidality during intake using the five Florida Network questions.</p>

Screening results are reviewed, signed by a supervisor, and filed in the youth's case record.	Compliance	Screening results are reviewed, signed by a supervisor, and accurately filed in each youth's case record.
A "yes" to any question triggers a full suicide risk assessment by: 1. A Licensed Mental Health Professional (LMHP), or 2. A non-licensed clinician under direct LMHP supervision.	Compliance	All screens that triggered a positive response for suicide risk demonstrated that a full suicide risk assessment was completed by a qualified LMHP or a clinician under direct LMHP supervision.
Assessment of Suicide Risk must be completed and reviewed by the LMHP within 24 hours of a positive screen.	Exception	Two out of four residential files reviewed did not have an Assessment of Suicide Risk completed within 24 hours. The agency reported no eligible items for community counseling available for review.
All assessments (initial and follow-up) are documented in detail: youth comments, behaviors, observations, risk indicators, supervision recommendations, treatment/follow-up, and signed and dated by the LMHP.	Compliance	Assessments are thoroughly documented, capturing all relevant observations, youth statements, risk indicators, and follow-up actions, with proper LMHP signature and date.
If conducted by a non-licensed staff member, the LMHP must co-sign and date as reviewer the next time they are on-site.	Compliance	When assessments are conducted by non-licensed staff, LMHPs consistently co-sign and date the review during their next on-site visit.
Parents/guardians and the Program Supervisor are notified immediately of any youth determined to be at risk or following a suicide attempt. All notification efforts (in-person, phone, certified mail) are documented in the case file.	Not Applicable	Four out four residential files reviewed were not applicable due to this requirement being applicable only for Community Counseling. The agency reported no eligible items for community counseling available for review. Agency Clinical Director reported to reviewer there were no youth that scored positive or indicated suicide risk for review period.
If a youth poses an immediate threat to self or others at any time, staff follow Baker Act protocols and/or call 911.	Compliance	Staff respond appropriately to any immediate threats by following Baker Act protocols or contacting emergency services as required.
Documentation & Family Notification		
All screenings, assessments, supervision actions, and shift-to-shift handoffs are logged in the daily shelter/counseling logbook.	Compliance	All screenings, assessments, supervision activities, and shift-to-shift handoffs are clearly recorded in the daily logbook.
If a guardian cannot be reached in person, telephone contact attempts are documented; and written notice is sent by certified mail.	Not Applicable	Four out four residential files reviewed were not applicable due to this requirement being applicable only for Community Counseling. The agency reported no eligible items for community counseling available for review. Agency Clinical Director reported to reviewer there were no youth that scored positive or indicated suicide risk for review period.

<p>When an immediate assessment is not possible, families receive community resource information.</p>	<p>Not Applicable</p>	<p>Four out four residential files reviewed were not applicable due to this requirement being applicable only for Community Counseling. The agency reported no eligible items for community counseling available for review. Agency Clinical Director reported to reviewer there were no youth that scored positive or indicated suicide risk for review period.</p>
<p>Community Counseling Only: Any screening conducted on school property during school hours is reported to appropriate school authorities.</p>	<p>Not Applicable</p>	<p>The agency reported no eligible items for review. Agency Clinical Director reported to reviewer there were no youth that scored positive or indicated suicide risk for review period.</p>
<p>Residential Only: Youth with a positive suicide screen are placed on Constant Sight & Sound Supervision until assessed by a licensed professional or non-licensed professional under the direct supervision of the licensed professional.</p>	<p>Compliance</p>	<p>Youth with a positive suicide screen are immediately placed on Constant Sight and Sound Supervision until assessment by a qualified professional occurs.</p>
<p>Residential Only: Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.</p>	<p>Compliance</p>	<p>Youth are consistently placed on the appropriate supervision level according to suicide risk assessment results.</p>
<p>Residential Only: Staff document observations (time, behavior notes, warning signs, initials) at intervals no longer than 30 minutes.</p>	<p>Compliance</p>	<p>Staff maintain detailed observation logs every 30 minutes, noting time, behavior, warning signs, and initials.</p>
<p>Residential Only: The assigned supervision level remains in place until a follow-up assessment by an LMHP (or supervised unlicensed clinician) confirms safety or the youth is diverted via Baker Act.</p>	<p>Compliance</p>	<p>The assigned supervision level remains active until a follow-up assessment by an LMHP (or supervised clinician) confirms safety or the youth is diverted per Baker Act procedures.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		

6.3 - Healthcare Admission Screening		Satisfactory
		Yes
Provider has a written policy and procedure that meets the requirement for Indicator 6.3		The agency has a policy called 6.3 Health Admission Screening. The policy was revised on 10/9/2025. The CEO reviewed and signed the policy on 11/25/2025.
A total of eight Healthcare Admissions Screening file(s) were reviewed during this evaluation period. Of these, four were open and four were closed.		
The primary healthcare screening is completed by the nurse if he/she is present during the intake. If not present during the intake, the nurse reviews the primary healthcare screening within 3 business days.	Compliance	The nurse completes the primary healthcare screening when present at intake, or reviews it within three business days if not on-site.
The primary healthcare screening and observations include:		
Current medications	Compliance	The primary healthcare screening includes verification and documentation of all current medications.
Existing (acute and chronic) medical conditions	Compliance	Existing acute and chronic medical conditions are accurately identified and recorded.
Allergies	Compliance	Any allergies are clearly documented during the screening process.
Recent injuries or illnesses	Compliance	Recent injuries or illnesses are reviewed and noted as part of the assessment.
Observation for evidence of illness, injury, pain or physical distress, difficulty moving, etc.	Not Applicable	Evidence of illness is not applicable for all youth files reviewed.
Acute health symptoms requiring quarantine or isolation	Not Applicable	Acute health symptoms are not applicable for all youth files reviewed.
Parents are involved with the coordination and scheduling of follow-up medical appointments, as appropriate.	Not Applicable	Not applicable for any youth files reviewed.
The program has procedures to include a thorough referral process and a mechanism for necessary follow-up medical care for youth admitted with chronic medical conditions.	Compliance	The program has established procedures to ensure youth with chronic medical conditions receive appropriate medical referrals and follow-up care. Any medical needs that are identified at admission receive the appropriate referrals as required.
All medical referrals are documented on a daily log.	Compliance	All medical referrals are documented daily in the log as required.
Additional Comments: There are no additional comments for this indicator.		

6.4 - Medical/Mental Health Alert Process		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 6.4		Yes
		The agency has a policy called 6.4 Medical/Mental Health Alert Process. The policy was revised on 10/9/2025. The CEO reviewed and signed the policy on 11/25/2025.
A total of seven Medical/Mental Health Alert Process file(s) were reviewed during this evaluation period. Of these, four were open and three were closed.		
If youth has a medical or mental health condition or allergies, they are appropriately placed on the program’s alert system.	Compliance	Youth with medical or mental health conditions or allergies are appropriately flagged in the program’s alert system to ensure staff awareness and safety.
Alert system includes precautions concerning prescribed medications and potential side effects.	Compliance	The alert system includes detailed precautions regarding prescribed medications and their potential side effects.
Staff are provided sufficient information/ instructions to recognize/respond to the need for emergency care for medical/mental health problems.	Compliance	Staff receive clear information and instructions enabling them to recognize and appropriately respond to medical or mental health emergencies.
A medical and mental health alert system is in place that ensure information concerning a youth’s medical condition, allergies, common side effects of prescribed medication, foods and medications that are contraindicated, or other pertinent mental health treatment information is communicated to all staff.	Compliance	A comprehensive medical and mental health alert system is in place, ensuring that all relevant information, including allergies, medication contraindications, and treatment considerations, is effectively communicated to all staff.
Additional Comments: There are no additional comments for this indicator.		