



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

**Boys Town**

975 Oklahoma Street  
Oviedo, FL 32765

**Date: December 3-4, 2025**

**Compliance Monitoring Services Provided by**



## EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for Boys Town of Central Florida for the FY 2025-2026 at its program office located at 975 Oklahoma Street Oviedo, Florida 32765. 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. Boys Town of Central Florida 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 Marcia Tavares, Consultant for Forefront LLC. Agency representatives from Boys Town of Central Florida present for the entrance interview were: Desmond Crayton, Executive Director; Melissa White, License Mental Health Counselor; Samuel Barber, Interim Program Director; Rochelle Davis, Program Support; Devonte Johnson, Shelter Supervisor; Porsha Davis, In-Home Family Service Administrative Assistant; and Carmen Rodriguez, Business Manager. The last onsite QI visit was conducted on December 4, 2024.

In general, the Reviewer found that Boys Town of Central Florida is in compliance with specific contract requirements. **Boys Town of Central Florida received an overall compliance rating of 100% for achieving full compliance with 13 applicable indicators** of the CINS/FINS Monitoring Tool. There were no recommendations or corrective actions as a result of the monitoring visit.

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

**2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL**  
**Report Number: CM 12-03-2025-2026**

<b>Agency Name: Boys Town of Central Florida</b>					<b>Monitor Name: Marcia Tavares, Lead Reviewer</b>		
<b>Contract Type : CINS/FINS</b>					<b>Region/Office: 975 Oklahoma Street, Oviedo, FL 32765</b>		
<b>Service Description: Comprehensive Onsite Compliance Monitoring</b>					<b>Site Visit Date(s): December 3-4, 2025</b>		
<b>Major Programmatic Requirements</b>	<b>Explain Rating</b>					<b>Ratings Based Upon:</b> <b>I = Interview</b> <b>O = Observation</b> <b>D = Documentation</b> <b>PTV = Submitted Prior To Visit</b> <b>(List Who and What)</b>	<b>Notes</b>  <b>Explain Unacceptable or Conditionally Acceptable:</b>
	<b>Unacceptable</b>	<b>Conditionally Acceptable</b>	<b>Fully Met</b>	<b>Exceeded</b>	<b>Not Applicable</b>		
<b>I. Administrative and Fiscal</b>							
<b>DJJ Quality Improvement Peer Reviewer</b> a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Documentation:</b> Boys Town of Central Florida currently has two certified Peer Reviewers, Rochelle Davis, Program Services Coordinator, and Devonte Johnson, Shelter Supervisor. Ms. Davis participated in at least one QI review during the past 12-month period.	
<b>Additional Contracts</b> a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. <b>PTV</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Documentation:</b> The agency maintains a list of 21 additional funding contracts for FY 2025-2026. The list includes: the contract type, contract title, funder name, contract amount, start and end date, and status. All of the funding contracts were listed as active with auto-renew or valid contract dates. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. All of the MOUs reviewed during the QI visit had current contract/agreement dates.	

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<b>Limits of Coverage</b> a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of \$100,000 per accident, \$100,000 per person and \$500,000 policy aggregate. Commercial General Liability with a limit of \$500,000 per occurrence, and \$1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of \$250,000 per person; with a minimum limit for bodily injury of \$500,000 per accident; with a minimum limit for property damage of \$100,000 per accident and with a minimum limit for medical payments or \$5,000-\$10,000 per person. Florida Network is listed as payee or co-payee. <b>PTV</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency provided a certificate of insurance produced by Arthur Gallagher Risk Management Services, LLC. All coverages are effective from 10/01/2025-10/01/2026 with the exception of Worker's Compensation from 12/31/2024-12/31/2025. Philadelphia Indemnity Insurance Company provides the following coverages and limits: Commercial General Liability for limits of \$1,000,000 each occurrence/\$3,000,000 aggregate; \$100,000 damage to rented premises; \$20,000 medical expense; \$1,000,000 for personal injury; \$3,000,000 product aggregate; automobile liability with a combined single limit of \$1,000,000; and umbrella liability with a \$10,000,000 limit per occurrence and \$10,000,000 aggregate. Workers' compensation and employee liability is provided through Sentry Insurance Company with limits of \$1,000,000 each occurrence, \$1,000,000 each disease/employee, and \$1,000,000 policy limit. The certificate lists the Florida Network of Youth and Families as a certificate holder.	

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<b>External/Outside Contract Compliance</b> a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	During the entrance meeting, the provider indicated there are no outstanding corrective action items cited by an external funding source.	
<b>Fiscal Practice</b> a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. <b>PTV</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: The agency maintains Accounting Policies and Procedures in place for: fiscal management, cash, petty cash, support, program service fees, revenue, and receivables, expenses for program and supporting services and accounts payable, payroll and related liabilities, governmental financial assistance programs, property and equipment, debt and other liabilities. The procedures reviewed appear to be consistent with GAAP and provide sound internal controls, and revision numbers are indicated for each procedure.	
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). <b>PTV</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Two separate General Ledgers were submitted for Boys Town Central Florida In Home Family Services (IHFS) Cost Center: CC-3110-02 and Intervention and Assessment (I&A) Cost Center: CC-3240-02 for the period January 1 – October 31, 2025. Agency maintains a detailed general ledger that is structured to	

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						track all funding sources as well as activities for the CINS/FINS program. Although centralized, the agency is allocating cost per each program from other funding sources separately. The GL uses a chart of accounts and each entry includes at a minimum, the type of transaction, date, cost center, and amount.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) – <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Boys Town has fiscal procedures for petty cash. Petty cash is stored in a locked box in the program director's office. Receipts are uploaded into WorkDay every week, by the purchaser and their supervisor approve each purchase for the Business Office to review and approve for reimbursement from the corporate office by the 28 <sup>th</sup> of each month. Reimbursement comes in the form of a check made out to the Program Director, who will then cash it and place the money in the petty cash box. The fund does not exceed \$200. In addition to petty cash, Supervisors have purchasing cards.	
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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Bank reconciliations for May-October 2025. Per the Business Manager, there is no local banking	

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monthly basis with supporting documentation and documentation provided contained 2 signatures. (Disbursements/invoices are approved & monitored by management). <b>ON SITE</b>						conducted by the local provider. All banking is managed on a corporate level. Bank reconciliations are conducted monthly by the corporate accounting staff. Observation of reconciliation reports confirms the bank statements are reconciled within six weeks of receipt. Invoices are processed and paid by the corporate business office. Local expenses are uploaded on WorkDay and can be reviewed and approved on WorkDay. Daily payments for expenses are made directly from the corporate accounting department.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over \$1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. <b>PTV/ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Per the Executive Director, the agency does not have any inventory purchased with funds from the Florida Network of Youth and Family Services.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), <u>Employee</u> IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Salaries are paid through ADP Tax Services. Taxes, benefits, and expenses are paid through ADP. Agency provided Statement of Accounts for June-November 2025, referencing invoice numbers and	

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						corresponding payments of payroll taxes paid to the IRS.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. <b>PTV/ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Agency provided budget to actual year-to-date report as of October 2025 for accounts 81270 (IHFS) and 81240 (I&A). The report shows actual expenses and annual budget with total variance. Variances in budget are monitored on a regular basis and are discussed with the Board of Directors.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than \$750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. <b>Can obtain from FNYFS</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Financial audit conducted for year ending December 31, 2024, was completed by KPMG LLP. A separate Management Letter requiring a Corrective Action Plan was not issued by the auditor as there were no findings and questioned costs.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Review of the following policies and procedures: Privacy and Confidentiality (Revision 49), Information Security Program (Revision 37), Retention, Storage, Destruction (Revision 11), Information Security (Revision 30), Physical and Environmental Protection	

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documents are shredded and computer hard drives are wiped prior to discarding. <b>ON SITE</b>						(Revision 32), and Safeguarding Protected Health Information (Revision 24).	
j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least \$19.00 per hour. This also includes funding for additional staff as approved by the Department. <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: A review of the agency's current salary list shows evidence that every direct care staff is paid at least \$19.00 per hour.	
<b>Disaster Planning</b> 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: o Emergency evacuation protocols o Severe weather procedures o Evacuation logistics (shelter only) o Evacuation facility designation (shelter only) o Critical Resource Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: The provider maintains an Emergency Disaster Plan for 2025-2026 that includes a procedural guide in emergency situations. The most recent annual review of the plan was conducted April 21, 2025 and approved on 10/30/25 by the Executive Director.  The Universal Agreement/Emergency Disaster Shelter document was signed by the agency executive on 6/24/2025.	

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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. <b>ON SITE</b>						

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**CONCLUSION**

Boys Town of Central Florida has met the requirements for the CINS/FINS contract as a result of full compliance with 13 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the fifteen indicators were not applicable because the agency does not have any inventory purchased with funds from the Florida Network of Youth and Family Services and has reported there are no corrective action items from external funding sources. Consequently, **the overall compliance rate for this contract monitoring visit is 100%**. There are no recommendations or corrective actions cited as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

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



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

Review of Boys Town of Central Florida  
CINS/FINS Program

Date: December 3-4, 2025

Compliance Monitoring Services Provided by



## CINS/FINS Rating Profile

### Domain 1: Background Screening and Compliance

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

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

### Domain 3: Screening, Assessment & Case Management

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

**Percent of indicators rated Satisfactory: 62.5 %**  
**Percent of indicators rated Limited: 37.5 %**  
**Percent of indicators rated Failed: 0 %**

### Domain 5: Shelter Program Services

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

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

### Domain 6: Medication Management

<b>6.0 Medication Management and Distribution</b>	<b>Satisfactory</b>
<b>6.1 Naloxone Administration and Opioid Overdose Response</b>	<b>Satisfactory</b>
<b>6.2 Suicide Prevention</b>	<b>Failed</b>
<b>6.3 Healthcare admission Screening</b>	<b>Satisfactory</b>
<b>6.4 Medical/Mental Health Alert Process</b>	<b>Satisfactory</b>

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

### Overall Rating Summary

**Percent of indicators rated Satisfactory: 81.25 %**  
**Percent of indicators rated Limited: 16.67 %**  
**Percent of indicators rated Failed: 3.33 %**

### Rating Definitions

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

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

### Reviewers

#### Members

- Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
- Luis Rodriguez – Regional Monitor, Department of Juvenile Justice
- Elijah McCloud – Family Resources
- Stephanie Paschall – CDS Family and Behavioral Health
- Pamela Washington – Arnette House

### 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

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

### Documents Reviewed

<input type="checkbox"/> Accreditation Reports	<input checked="" type="checkbox"/> Table of Organization	<input type="checkbox"/> Visitation Logs
<input checked="" type="checkbox"/> Affidavit of Good Moral Character	<input checked="" type="checkbox"/> Fire Prevention Plan	<input checked="" type="checkbox"/> Youth Handbook
<input checked="" type="checkbox"/> CCC Reports	<input checked="" type="checkbox"/> Grievance Process/Records	5 # Health Records
<input checked="" type="checkbox"/> Logbooks	<input type="checkbox"/> Key Control Log	5 # MH/SA Records
<input checked="" type="checkbox"/> Continuity of Operation Plan	<input checked="" type="checkbox"/> Fire Drill Log	9 # Personnel /Volunteer Records
<input checked="" type="checkbox"/> Contract Monitoring Reports	<input checked="" type="checkbox"/> Medical and Mental Health Alerts	8 # Training Records
<input type="checkbox"/> Contract Scope of Services	<input checked="" type="checkbox"/> Precautionary Observation Logs	9 # Youth Records (Closed)
<input checked="" type="checkbox"/> Egress Plans	<input checked="" type="checkbox"/> Program Schedules	6 # Youth Records (Open)
<input checked="" type="checkbox"/> Fire Inspection Report	<input checked="" type="checkbox"/> List of Supplemental Contracts	<input type="checkbox"/> # Other: ____
<input type="checkbox"/> Exposure Control Plan	<input checked="" type="checkbox"/> Vehicle Inspection Reports	____

### Observations During Review

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

### Surveys

<input type="checkbox"/> 6 # of Youth	<input type="checkbox"/> 2 # of Direct Staff	<input type="checkbox"/> # of Other	<input type="checkbox"/>
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## 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

Boys Town of Central Florida is located at 975 Oklahoma Street, Oviedo, FL 32765. The provider offers a residential program, Intervention and Assessment (I&A), as well as community counseling services, In Home Family Services (IHFS), to boys and girls throughout the Oviedo and surrounding areas of central Florida. Population served through Florida Network funding includes Children in Need of Services/Family in Need of Services, Domestic Violence Respite, and Probation Respite services.

### 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 Limited

Indicator 1.4 Training Requirements was rated Limited

Indicator 1.5 Data Entry & Collection was rated Satisfactory with Exception(s)

Indicator 1.6 Risk Management/ Analyzing and Reporting Information was rated Satisfactory

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 with Exception(s)

Indicator 3.3 NIRVANA (Network Inventory of Risks, Victories, and Needs Assessment) was rated Limited

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

Indicator 3.5 Adjudication Services: Case Staffing was rated Satisfactory with Exception(s)

Indicator 3.6 Staffing and Youth Supervision was rated Satisfactory

Indicator 3.7 Service Plan was rated Limited

Indicator 3.8 Youth Records was rated Satisfactory

Indicator 3.10 Discharge and Follow Up was rated Limited

**Domain 5:** There are five indicators for Domain 5.

Indicator 5.0 Shelter Program Services was rated Satisfactory with Exception(s)

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

Indicator 5.2 Shelter Search Policy was rated Satisfactory

Indicator 5.3 Logbook Requirements was rated Satisfactory

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 with Exception(s)

**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 Failed

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 1: Limited Ratings**

- 1.3 - Incident Reporting: A total of six CCC incidents were reviewed. Incidents dated 11/21/25, 9/19/25, 10/15/25, 9/3/25, and 8/18/25 were not located in the logbook as required. Only one of the CCC incidents on 7/24/25 was documented in the logbook.
- 1.4 - Training Requirements: One of four staff did not complete Civil Rights and Federal Funds training within 30 days of their start date. Two of four staff did not complete the Contraband Overview Policy training before working independently with youth, and one of the two, hired in May 2025, had not completed the training as of the date of the QI review. One of four staff did not complete the Behavior Management training before working independently with youth. Two of four staff did not complete the building facility layout training before working independently with youth, and one of the two had not completed the training as of the date of the QI review. One of four staff did not complete the CCC & Incident Reporting training before working independently with youth. One of four staff did not complete the Child Abuse Reporting training before working independently with youth. Three of four staff did not have Client Intake and Screening training. Three of four staff did not have Client Orientation training. This training became effective July 1, 2025 after the hire date for staff records reviewed. One of four staff (hired April 2025) did not complete Medical and Mental Health Alerts System training as of the date of the QI review. One of four staff did not complete the Crisis Intervention training before working independently with youth. Three of four staff did not complete the Cultural Humility/Diversity training within the 90 day period. One of four staff did not complete Information and Security Awareness training within 90 days of hire. One of four staff did not complete PREA 1 training within 90 days of hire. One of four staff did not complete PREA 2 training within 90 days of hire. One of four staff did not complete Sexual Harassment training within 90 days of hire. One of four staff did not complete Trauma Responsive Practices training within 90 days of hire. One of four staff did not complete Adverse Childhood Experiences training within 90 days of hire. All four first year staff training records contained trainings not completed within the required timeframe. There was no documentation of the reason and/or expected completion date for trainings not completed to date. All four first year staff training records documented over 80 hours of training; however, all four records contained pre-service trainings that were not completed within the required timeframe.

**Domain 3: Limited Ratings**

- 3.3 - NIRVANA (Network Inventory of Risks, Victories, and Needs Assessment): Of the 10 files reviewed, the NIRVANA in one file was not signed or dated; therefore, reviewer was unable to tell if it was completed at intake or not. Out of 10 files reviewed, three of them were not entered into NETMIS within three business days. Out of 10 files reviewed, five community counseling records did not have the Supervisors signature on the NIRVANA within 7 business days and one of the five shelter files did not have a supervisor's signature. One of the five shelter files reviewed did not have evidence of a self-assessment completed. Of the 10 files reviewed, NIRVANA post assessment was applicable to six records. One of the six records did not provide evidence that a post assessment was completed.
- 3.7 - Service Plan: Three of five shelter files reviewed did not have evidence of the case plans being developed within seven days from the youth's intake. In all five of the community counseling cases reviewed, the case service plan is not developed within one session after completion of the NIRVANA. Of the 10 files reviewed, no files showed evidence of actual specific completion dates. Of the 10 files reviewed there is no evidence in six of the records showing the licensed mental health professional signed off of the initial plan within 7 days. There was no evidence of a clear initiation date of the service plan in two of the 10 files reviewed. One of three applicable shelter files reviewed was missing evidence of a 30 day review. Of the five community counseling files reviewed, the 30 day reviews were not completed within 30 days in all five files. Of the five community counseling files reviewed, three of the files reviewed did not show evidence of a 60 day review completed within 60 days. One applicable community counseling file did not show evidence of the 90 day review. There were no eligible court-ordered youth during the review period.
- 3.10 - Discharge and Follow-up: Of the 10 files reviewed, three of the files reviewed did not show evidence of a 30 day post follow up. Of the 10 files reviewed, two of the files did not have evidence of a 60-day post discharge follow up. Of the 10 files reviewed, all five shelter files did not have evidence of a NIRVANA post assessment. None of the

**Domain 6: Failed Indicator 6.2**

- 6.2 - Suicide Prevention: The program's current policy has the correct five suicide risk questions. However, six youth charts were reviewed and all six youth charts are using an outdated CINS/FINS Intake Assessment Form / Suicide Risk Screening. Six youth charts were reviewed and five out of the six youth charts do not have the LMHP signing the Youth Suicide Risk Assessment within 24 hours. Six youth charts were reviewed and two out of the six youth charts had no evidence of a follow-up or proper follow up assessment documentation. Two of three shelter youth were not placed on Constant Sight or Sound even though they checked 'yes' to the Suicide Risk Screening question(s). Six youth charts were reviewed and one out of the six youth charts did not have the LMHP signing the Youth Suicide Risk Assessment at all. Upon review of the safety plan dated 8/13/25, it was noted that the parental signature line was left unsigned by the parent. Parent notification was observed for all six youth charts reviewed. All six youth charts contained suicide assessments that were completed immediately. On 10/30/25 the youth was seen at their school and indicated "yes" to one of the Suicide Risk Assessment questions. However, the counselor did not notify school staff of the positive response before departing the school. Two out of the three youth were not placed on constant sight and sound supervision despite having answered 'yes' to the questions on the Suicide Risk Screening question(s). Two out of the three youth were not placed on the proper supervision based on the results of the Suicide Risk Screening. The proper observation documents were not started for two of the three of the youth that answered yes to the Suicide Risk Screening question(s). The appropriate level of supervision for two of the three youth was never implemented.

<b>CINS/FINS QUALITY IMPROVEMENT TOOL</b>		
<p><b>Quality Improvement Indicators and Results:</b>                      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><b>Summary/Narrative Findings:</b>                      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>	
<b>Domain One – Background Screening and Compliance</b>		
<b>1.0 - Background Screening</b>		<b>Satisfactory with Exception(s)</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.0</b>	Yes	
<b>Provider has implemented a Suitability Assessment policy and procedure that meets the requirement for Indicator 1.0</b>	Yes	
	<p>Policy 1.0, Background Screening, was last reviewed and approved 11/24/2025 by the Executive Director. The program utilizes the Hiring Manager Interview (HMI) pre-employment suitability assessment tool. The tool was previously based on a passing score of 26 points but was revised and updated to a passing score of 15 in 2025.</p>	
<b>A total of nine file(s) were reviewed during this evaluation period. Of these, eight new hire file(s) and one 5-year rescreen file(s) were reviewed. The sample included nine employee(s) and zero volunteer(s).</b>		
<b>Suitability Assessment</b>		
All positions providing direct services (residential and community counseling) to youth has successfully passed pre-employment suitability assessment on the initial attempt.	<b>Exception</b>	<p>There was no evidence one of eight new hires completed the Hiring Manager Interview (HMI) suitability assessment prior to hire in March 2025. The staff was referred to the CINS/FINS program after completing an interview for another agency program; however, a suitability assessment was never completed.</p>
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.	<b>Not Applicable</b>	<p>All seven applicable new hires who completed the HMI successfully passed the assessment on the first attempt.</p>

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.	<b>Not Applicable</b>	None of the new hires were previously employed by the program.
<b>New Hire</b>		
For New Hires-The background screening was completed and applicant determined eligible prior to date of hire.	<b>Compliance</b>	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.	<b>Not Applicable</b>	The provider has not utilized any interns or volunteers during the review period.
For those with ineligible background screenings, the exemption was obtained prior to working with youth.	<b>Not Applicable</b>	None of the background screenings completed for new hires during the review period required an exemption.
<b>E-Verify</b>		
The file contains proof of E-Verify for all new employees obtained from the Department of Homeland Security.	<b>Compliance</b>	All personnel files contained valid E-Verify confirmations from the Department of Homeland Security verifying employment eligibility.
<b>5 Year Rescreening</b>		
Five year re-screening was completed prior to the 5-year anniversary date of initial hire or prior to expiration of retained fingerprints date.	<b>Compliance</b>	All five-year re-screenings were completed on or before the employee’s five-year anniversary or fingerprint expiration date, whichever came first.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>1.1 - Annual Affidavit of Compliance with Good Moral Character Standards</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.1</b>		Yes
		Policy 1.1, Annual Affidavit of Compliance with Good Moral Character Standards, was last reviewed and approved 11/24/2025 by the Executive Director.
Affidavit of Annual Compliance with Level 2 Screening Standard (Form IG/BSU-006) is completed and submitted to BSU by January 31st.	<b>Compliance</b>	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	<b>Compliance</b>	Each affidavit submission included documented proof of delivery to BSU, verified through fax or email confirmation.
<b>Additional Comments: There are no additional comments for this indicator.</b>		

<b>1.2 - Provision of an Abuse Free Environment</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.2</b>		Yes
		Policy 1.2, Provision of an Abuse-Free Environment, was last reviewed and approved 11/24/2025 by the Executive Director.
The program has a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation.	<b>Compliance</b>	The program maintains and enforces a written Code of Conduct that strictly prohibits physical abuse, profanity, threats, or intimidation. All staff demonstrate adherence to these standards.
The program has a process in place for reporting and documenting any child abuse hotline calls.	<b>Compliance</b>	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.
Agency is an abuse free environment.	<b>Compliance</b>	Survey feedback confirms the agency maintains an abuse-free environment, with no reported concerns from staff or youth.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>1.3 - Incident Reporting</b>		<b>Limited</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.3</b>		Yes
		Policy 1.3, Incident Reporting, was last reviewed and approved 11/24/2025 by the Executive Director.
<b>Data sources Reviewed</b>	<b>Dates Reviewed</b>	<b>Logbook Dates for Sample Size:</b>
CCC Reports, Logbook entries, Incident Reports	June 1, 2025-December 2, 2025	8/18/2025 9/3/2025 10/15/2025 7/24/2025 9/19/2025 11/21/2025
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.	<b>Compliance</b>	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 CCC call is documented in the logbooks for Shelter programs.	Exception	A total of six CCC incidents were reviewed. Incidents dated 11/21/25, 9/19/25, 10/15/25, 9/3/25, and 8/18/25 were not located in the logbook as required. Only one of the CCC incidents on 7/24/25 was documented in the logbook .
Agency internal incidents are documented on incident reporting forms or electronically.	Compliance	Internal incidents were documented on the proper reporting forms or electronically.
All incident reports are reviewed and signed by program supervisors/directors.	Compliance	All incident reports were reviewed and signed by program supervisors or directors.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>1.4 - Training Requirements</b>	<b>Limited</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.4</b>	Yes	
	Policy 1.4, Staff Training and Professional Development, was last reviewed and approved 11/24/2025 by the Executive Director.	
<b>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).</b>		
<b>Policy &amp; New Hire Training</b>		
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)	Exception	One of four staff did not complete Civil Rights and Federal Funds training within 30 days of their start date.
<b>Pre-Service Training</b>		
Agency policies and procedures	Compliance	All new staff completed agency orientation and policy training prior to working independently.

**December 3-4, 2025**

Contraband Overview and Search Policy/Practice AND signed acknowledgment form by staff.	<b>Exception</b>	Two of four staff did not complete the Contraband Overview Policy training before working independently with youth and one of the two, hired in May 2025, had not completed the training as of the date of the QI review.
Behavior Management	<b>Exception</b>	One of four staff did not complete the Behavior Management training before working independently with youth.
Building/Facility layout	<b>Exception</b>	Two of four staff did not complete the building facility layout training before working independently with youth, and one of the two had not completed the training as of the date of the QI review.
File Documentation/Paperwork Requirements	<b>Compliance</b>	File documentation and paperwork requirement training was completed as required.
Confidentiality (FYSB / DCF / Skill Pro)	<b>Compliance</b>	Confidentiality training (FYSB / DCF / SkillPro) was completed and documented in staff files.
CCC & Incident Reporting	<b>Exception</b>	One of four staff did not complete the CCC & Incident Reporting training before working independently with youth.
Child Abuse Reporting	<b>Exception</b>	One of four staff did not complete the Child Abuse Reporting training before working independently with youth.
Client Intake & Screening	<b>Exception</b>	Three of four staff did not have Client Intake and Screening training.
Client Orientation (Shelter Only)	<b>Exception</b>	Three of four staff did not have Client Orientation training.
Fire Safety Equipment (In-person by a supervisor or other program trainer)	<b>Compliance</b>	Fire Safety Equipment training was completed in person by a supervisor or program trainer.
Fire Safety Equipment (Skill Pro #215 or DCF)	<b>Not Applicable</b>	This training became effective July 1, 2025 after the hire date for staff records reviewed.
Medical and Mental Health Alert System	<b>Exception</b>	One of four staff (hired April 2025) did not complete Medical and Mental Health Alerts System training as of the date of the QI review.
Disaster Preparedness	<b>Compliance</b>	Disaster Preparedness training was completed and verified in training logs.
Universal Precautions / Communicable Diseases / Infection Control / Bloodborne Pathogens Part I & II	<b>Compliance</b>	Universal Precautions, Communicable Diseases, Infection Control, and Bloodborne Pathogens Parts I & II training were completed and documented.
CPR/First Aid (By CPR Certified Instructor)	<b>Compliance</b>	CPR/First Aid training was completed by a certified instructor prior to independent duty.
Video Camera Surveillance & Equipment	<b>Compliance</b>	Staff completed Video Camera Surveillance and Equipment training prior to shift assignment.
CINS/FINS Core	<b>Compliance</b>	CINS/FINS Core training was completed and verified.

Crisis Intervention [e.g., MAB (2-day/16 hours) or other FN approved training]	Exception	One of four staff did not complete the Crisis Intervention training before working independently with youth.
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	Exception	Three of four staff did not complete the Cultural Humility/Diversity training within the 90 day period.
Mental Health and Substance Abuse	Compliance	Mental Health and Substance Abuse training was completed and documented in the staff record.
<b>Skill Pro Required Trainings:</b>		
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	Exception	One of four staff did not complete Information and Security Awareness training within 90 days of hire.
Prison Rape Elimination Act (PREA) - Part 1	Exception	One of four staff did not complete PREA 1 training within 90 days of hire.
Prison Rape Elimination Act (PREA) - Part 2	Exception	One of four staff did not complete PREA 2 training within 90 days of hire.
Sexual Harassment	Exception	One of four staff did not complete Sexual Harassment training within 90 days of hire.
Trauma Responsive Practices	Exception	One of four staff did not complete Trauma Responsive Practices training within 90 days of hire.
<b>Additional FL Network Required Trainings:</b>		
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)	Exception	One of four staff did not complete Adverse Childhood Experiences training within 90 days of hire.
FL Statute 984 CINS Petition Training (Case Staffing & CINS Petition Staff Only )	Not Applicable	None of the four staff conduct case staffing duties.
<b>STAFF SPECIFIC TRAINING - Florida Network and SkillPro Required Trainings Related to Specific Staff Roles</b>		
JJIS (Juvenile Justice Information System) System Access (Required for staff who enter and monitor SVS prior to accessing JJIS)	Not Applicable	None of the four staff were responsible for entering data into JJIS.

JJIS Alerts – Part 1 (JJIS Data Entry Staff prior to accessing JJIS)	<b>Not Applicable</b>	None of the four staff were responsible for entering data into JJIS.
JJIS Alerts – Part 2 (JJIS Data Entry Staff prior to accessing JJIS)	<b>Not Applicable</b>	None of the four staff were responsible for entering data into JJIS.
Motivational Interviewing (MI) (Prior to NIRVANA training for Staff who Administer the NIRVANA)	<b>Compliance</b>	Staff responsible for administering the NIRVANA® completed Motivational Interviewing (MI) training prior to NIRVANA® instruction.
NIRVANA Assessment (Required for all staff who Administer the NIRVANA, prior to administering the NIRVANA)	<b>Compliance</b>	Staff assigned to conduct NIRVANA® assessments completed NIRVANA® training prior to administering the assessment, verified with the Lead.
Medication Distribution for Shelter Staff Without a Medical License (Prior to administration of medication and annually)	<b>Compliance</b>	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)	<b>Compliance</b>	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	<b>Not Applicable</b>	Boys Town does not provide SNAP services.
SNAP Facilitator Training (Required for All Staff prior to the delivery of Groups)	<b>Not Applicable</b>	Boys Town does not provide SNAP services.
NetMIS Training (For NetMIS Users prior to accessing NetMIS)	<b>Not Applicable</b>	None of the four staff were responsible for entering data into NetMIS.
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)	<b>Not Applicable</b>	There were no eligible non-licensed shelter clinical staff hired during the review period.

<p>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*</p>	<p><b>Not Applicable</b></p>	<p>There were no eligible non-licensed shelter clinical staff hired during the review period.</p>
<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><b>Not Applicable</b></p>	<p>There were no eligible non-licensed shelter clinical staff hired during the review period.</p>
<p>For any trainings that are NOT completed within the required timeframe, includes documentation of the reason and scheduled completion date.</p>	<p><b>Exception</b></p>	<p>All four first year staff training records contained trainings not completed within a required timeframe. There was no documentation of the reason and/or expected completion date for trainings not completed to date.</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><b>Exception</b></p>	<p>All four first year staff training records documented over 80 hours of training; however, all four records contained pre-service trainings that were not completed within a required timeframe.</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><b>Not Applicable</b></p>	<p>None of the four training records indicated a break in employment for respective staff.</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><b>Not Applicable</b></p>	<p>None of the four training records indicated instructor was not available to conduct trainings.</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.	Compliance	The agency has a designated staff member responsible for managing all employee training files and routinely reviews them to ensure compliance.
All Network-required training is supported by documentation such as certificates, sign-in sheets, and agendas.	Compliance	All Network-required trainings are supported by appropriate documentation, including certificates, sign-in sheets, and training agendas.
<b>Annual Training</b>		
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)	Exception	One of four staff did not complete Human Trafficking training during the annual timeframe.
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.
<b>FL Network Annual Required Trainings REQUIRED for Staff Over 1 year</b>		
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)	<b>Compliance</b>	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))"	<b>Compliance</b>	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)"	<b>Compliance</b>	In-person Fire Safety Equipment training is completed every two years and properly documented.
Virtual "Fire Safety Equipment (Every 2 years)"	<b>Not Applicable</b>	This training became effective July 2025, outside of the annual training review period for the four staff records reviewed.
Medication Distribution for Staff Without a Medical License (Re-certification annually)	<b>Compliance</b>	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)	<b>Not Applicable</b>	Boys Town does not provide SNAP services.
For missed trainings, documentation includes the reason for delay and scheduled completion timeline.	<b>Exception</b>	The reason was not indicated for the missed training in one of the four records reviewed.
All direct care Community Counseling staff meet the annual requirement of a minimum of 24 hours of total hours of training received for the year.	<b>Compliance</b>	All direct-care Community Counseling staff meet the annual minimum requirement of 24 total training hours.
All direct care Shelter Staff meet the annual requirement of a minimum of 40 hours for residential programs licensed by DCF of total hours of training received for the year. **This includes residential counselor or other direct care staff positions working with youth in shelter.**	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	All Network-required trainings are supported by documentation such as certificates, sign-in sheets, and training agendas.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>1.5 - Data Entry &amp; Collection</b>	<b>Satisfactory with Exception(s)</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.5</b>	Yes	
	Policy 1.5, Data Entry and Collection, was last reviewed and approved 11/24/2025 by the Executive Director.	

<p>The program has a quality improvement process in place to review and improve accuracy of data entry and collection.</p>	<p><b>Compliance</b></p>	<p>The program maintains an active quality improvement process to review and enhance the accuracy of data entry and collection.</p>
<p>Client and service data is entered electronically into the Florida Network Management Information System (NetMIS) within three (3) business days of service commencement (as reported on most recent End-of-Month ('EOM') report).</p>	<p><b>Exception</b></p>	<p>Florida Network Report Card for November 2025 shows 92% of intake and discharge data entered into NetMIS within 3 business days as required. Client records reviewed did not demonstrate all services provided were entered into NetMIS.</p>
<p>Monthly review of statewide End-of-Month ('EOM') reports is evidenced. 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><b>Compliance</b></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><b>Additional Comments: There are no additional comments for this indicator.</b></p>		
<p><b>1.6 - Risk Management/ Analyzing and Reporting Information</b></p>	<p><b>Satisfactory</b></p>	
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 1.6</b></p>	<p>Yes Policy 1.6, Risk Management/Analyzing and Reporting Information, was last reviewed and approved 11/24/2025 by the Executive Director.</p>	
<p><b>Data sources Reviewed</b> Youth Records Reviews Agenda and Meeting Minutes past 6 months Compliance Leadership meetings. Client Satisfaction Report Card. Quarterly National QMC meetings. Data Integrity meetings and reports. 2025 Balanced Scorecard. Program Implementation Tool.</p>	<p><b>Dates Reviewed</b>  Quarters 2 and 3 FY 24-25 and past 6 months.</p>	
<p>The program provides reports of aggregated data and committee/workgroup minutes analyzing information.</p>	<p><b>Compliance</b></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>

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.)	<b>Compliance</b>	Quarterly case record reviews are conducted as required, with summary reports identifying compliance with CINS/FINS standards. Results are reviewed by management and communicated to staff on a quarterly basis.
The program reviews incidents, accidents, and grievances at least quarterly	<b>Compliance</b>	The program conducts regular reviews of all incidents, accidents, and grievances at least quarterly, ensuring timely analysis, corrective actions, and preventive measures.
The program reviews customer satisfaction data at least annually.	<b>Compliance</b>	Customer satisfaction data is reviewed annually, and feedback is used to enhance service quality and client experience.
The program reviews outcome data at least annually.	<b>Compliance</b>	Program outcome data is reviewed annually to assess performance against goals and inform quality improvement efforts.
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	<b>Compliance</b>	Findings from reviews are consistently evaluated by management and effectively communicated to staff and stakeholders to ensure transparency and alignment.
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.	<b>Compliance</b>	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 strengths and weaknesses are identified, improvements are implemented or modified and staff are informed and involved throughout the process	<b>Compliance</b>	Documentation reflects that program strengths and weaknesses are identified, corrective actions implemented, and staff are informed and engaged throughout the improvement process.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>1.7 - Client Transportation</b>		<b>Satisfactory with Exception(s)</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.7</b>		Yes
		Policy 1.7, Transportation of Youth, was last reviewed and approved 11/24/2025 Executive Director.
Supervisors complete a weekly review of transport documentation and provide written feedback or coaching when deficiencies are found.	<b>Exception</b>	The program was unable to provide weekly supervisory review of transportation documentation for four of the six months reviewed.
The agency has a practice, review, and approval process in place regarding the transportation of youth assigned to the program.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	All youth records for applicable single youth transports contained signed parental consent in advance of any single transport.
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.	<b>Compliance</b>	Evidence shows that program directors reviewed and approved all single-staff transports prior to travel, and approvals were properly documented.
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.	<b>Compliance</b>	All single-staff transports included required phone check-ins with a senior program leader or designee upon departure and arrival, with each check-in documented by the receiving manager.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>1.8 - Client Contact Policy</b>	<b>Satisfactory</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.8</b>	Yes	
	Policy 1.8, Client Contact Policy, was last reviewed and approved 11/24/2025 by the Executive Director.	
<b>Additional Comments: There are no additional comments for this indicator.</b>		

1.9 - Community Referrals and Outreach Services		Satisfactory with Exception(s)
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 1.9</b></p>	Yes	Policy 1.9, Community Referrals and Outreach Services, was last reviewed and approved 11/24/2025 by Executive Director.
	<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. 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><b>Compliance</b></p>
<p>The program has evidence that provides minutes of the event or other verification of staff participation.</p>	<p><b>Exception</b></p>	<p>The program provided five Community Advisory Board Agendas that included meeting minutes, staff roster, local law enforcement, and stakeholders, and dates: 2/19/25, 5/21/25, 8/20/25, 10/29/25, 11/19/25; however, four NetMIS outreach activity events conducted on 6/4/25, 7/20/25, 7/29/25, and 8/2/25 did not provide proof of staff participation for those events.</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><b>Compliance</b></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><b>Compliance</b></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><b>Compliance</b></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>

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.	<b>Compliance</b>	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.
The program maintains written agreements with other community partners, which include services provided and a comprehensive referral process.	<b>Compliance</b>	The program maintains current written agreements with community partners outlining provided services and a clearly defined referral process that supports coordinated care.
Copies of agreements are forwarded to the Florida Network.	<b>Compliance</b>	Copies of all partnership agreements are submitted to the Florida Network as required, ensuring transparency and statewide coordination of services.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>Domain Three</b>		
<b>3.2 - Admission Process</b>		<b>Satisfactory with Exception(s)</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.2</b>		Yes
		Policy 3.2, Admission Process, was last reviewed and approved 11/24/2025 by the Executive Director.
<b>A total of ten file(s) were reviewed during this evaluation period. Of these, five were open and five were closed. Among the open file(s), one residential (RES) and four community counseling file(s) were reviewed. Among the closed file(s), four residential (RES) and one community counseling file(s) were reviewed.</b>		
The screening form is completed immediately for all inquiries into shelter placement.	<b>Compliance</b>	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.	<b>Exception</b>	One of the five files reviewed had a screening date of 9/24/25 and intake appeared to be 10/22/25, exceeding the three business days required.
<b>Youth and parents/guardians receive the following in writing</b>		
Youth and parents/guardians are provided available service options in writing.	<b>Compliance</b>	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.	<b>Exception</b>	Out of 10 files reviewed there is no proof of the youth receiving information about their Rights and Responsibilities in six files.
Parents/guardians are provided “Rights and Responsibilities of Parents” and/or parent brochure.	<b>Compliance</b>	Parents and guardians were provided the “Rights and Responsibilities of Parents” brochure at intake, and signed acknowledgment forms were present in all records.
<b>The following is also available to the youth and parents/guardians:</b>		
Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication).	<b>Exception</b>	Out of 10 files reviewed five community counseling files did not have evidence of presenting possible actions through involvement with CINS/FINS services.
Youth and parents/guardians are provided information regarding the programs grievance procedures.	<b>Exception</b>	Of the 10 files reviewed, one of the shelter files did not have proof that the parent received information regarding grievance procedures.
If the youth and family do NOT participate in services, the reason is documented on the screening form and logged in NetMIS.	<b>Not Applicable</b>	All ten files reviewed demonstrated youth and/or parent participation in services.
The Intake took place in a setting that allows the client to feel safe and heard.	<b>Compliance</b>	Intakes were conducted in private, trauma-informed settings designed to help youth feel safe, respected, and heard throughout the process.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>3.3 - NIRVANA (Network Inventory of Risks, Victories, and Needs Assessment)</b>		<b>Limited</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.3</b>		Yes
		Policy 3.3, NIRVANA, was last reviewed and approved 11/24/2025 by the Executive Director.
For youth in shelter care: NIRVANA Assessment initiated within 72 hours of admission	<b>Compliance</b>	All youth admitted to shelter care had their NIRVANA Assessment initiated within 72 hours of admission, ensuring prompt evaluation and service engagement.
For youth in shelter care: NIRVANA Assessment is completed within seven (7) days from intake.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Exception</b>	Of the 10 files reviewed, the NIRVANA in one file was not signed or dated; therefore, reviewer was unable to tell if it was completed at intake or not.
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).	<b>Compliance</b>	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.	<b>Exception</b>	Out of 10 files reviewed, three of them were not entered into NETMIS within 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.	<b>Exception</b>	Out of 10 files reviewed, five community counseling records did not have the Supervisors signature on the NIRVANA within 7 business days and one of the five shelter files did not have a supervisor's signature.
(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.	<b>Exception</b>	One of the five shelter files reviewed did not have evidence of a self-assessment completed.
A NIRVANA Re-Assessment is completed every 90 days with the exception of SNAP services.	<b>Compliance</b>	All applicable youth received NIRVANA Re-Assessments every 90 days, excluding SNAP participants, maintaining ongoing progress monitoring.
All files must have the interview guide and/or printed NIRVANA.	<b>Compliance</b>	Each file reviewed contained a completed interview guide and/or a printed copy of the NIRVANA Assessment, demonstrating proper documentation and retention.
A NIRVANA Post-Assessment is completed at discharge for youth who have a length of stay that is greater than 30 days.	<b>Exception</b>	Of the 10 files reviewed, NIRVANA post assessment was applicable to six records. One of the six records did not provide evidence that a post assessment was completed.
<b>Additional Comments: There are no additional comments for this indicator.</b>		

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 Policy 3.7, Service Plan, was last reviewed and approved 11/24/2025 by the Executive Director.
Each client is assigned a Counselor.	Compliance	Each client was assigned a qualified counselor responsible for coordinating services and maintaining consistent therapeutic engagement.
<b>The following is also available to the youth and parents/guardians:</b>		
In the Shelter Program: Individual/Family Counseling services are provided to each client at least once per week by a licensed mental health provider or unlicensed staff working under the direct supervision of a licensed staff.	Exception	Out of 10 files reviewed two residential files did not have evidence counseling services were completed for all weeks that the youth was in shelter.
Community Counseling Program: Counseling sessions must be offered at a minimum once a week. (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)	Compliance	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.
The reason(s) why a required weekly session could not be provided is documented in the youth's file and in NetMIS.	Exception	Out of 10 files reviewed two files did not present evidence as to counseling the youth once per week and there was also no evidence presented as to the reason services were not provided.
If case management needs extend beyond the counselor's role, a case manager is assigned.	Compliance	When case management needs exceeded the counselor's role, a dedicated case manager was promptly assigned to ensure comprehensive service coordination.
Case Manager establishes appropriate referrals to services.	Compliance	Case managers established appropriate community referrals and coordinated follow-up services to address the youth's individual needs.
All counseling and case management sessions are documented in the youth's file and NetMIS, including the reason for missed session/s.	Exception	Out of 10 files reviewed, one of the shelter files did not show evidence why a counseling session was missed and two did not have any services entered into NETMIS.

<p>If mental health or substance abuse needs, outside of the program’s capacity, are identified appropriate referrals are made and documented.</p>	<p><b>Exception</b></p>	<p>Out of 10 files reviewed, one of the shelter files did not show evidence of an appropriate substance abuse/mental health referral being made.</p>
<p>For youth receiving Respite Services (DV, Probation &amp; 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><b>Exception</b></p>	<p>Out of 10 files reviewed, one was a DV case that did not show evidence of a date given to the legal guardians in an attempt to make a family session for re-unification.</p>
<p>Clients that do not receive services for 30 days or more have their case closed.</p>	<p><b>Not Applicable</b></p>	<p>None of the 10 files reviewed were lacking services to youth/family for 30 days or more.</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><b>Compliance</b></p>	<p>Direct supervision for Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals was documented on the MHSA 019 Supervision Log or equivalent program form containing all required information.</p>
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>		
<p><b>3.5 - Adjudication Services: Case Staffing</b></p>		<p><b>Satisfactory with Exception(s)</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 3.5</b></p>		<p>Yes</p>
		<p>Policy 3.5, Adjudication Services: Case Staffing, was last reviewed and approved 11/24/2025 by the Executive Director.</p>
<p><b>A total of two file(s) were reviewed during this evaluation period. Of these, one were open and one were closed. Among the open file(s), zero residential (RES) and one community counseling file(s) were reviewed. Among the closed file(s), zero residential (RES) and one community counseling file(s) were reviewed.</b></p>		
<p>A case staffing committee meeting is scheduled when one of the following occur (at minimum):</p> <ol style="list-style-type: none"> <li>1. the youth/family is not in agreement with services or treatment;</li> <li>2. the youth/family will not participate in the services selected,</li> <li>3. the youth’s referring problem has not shown substantial improvement within six weeks of initiating counseling.</li> <li>4. the program receives a written request from the parent/guardian or any other member of the committee</li> </ol>	<p><b>Compliance</b></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>

Each case staffing must be recorded in NetMIS within the case, noting the date it occurred.	<b>Exception</b>	None of the two case staffings held during the review period were entered into NetMIS.
The case staffing is convened within 7 days (excluding weekends and legal holidays) of the parent/guardian request.	<b>Not Applicable</b>	There were no parental requests for case staffing for the two records reviewed.
Notification to family no less than 5 working days prior to staffing.	<b>Compliance</b>	Families receive written notification of the staffing meeting at least five (5) working days prior to the scheduled date.
Notification to committee no less than 5 working days prior to staffing date.	<b>Compliance</b>	Committee members receive notification of the staffing meeting at least five (5) working days in advance.
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations.	<b>Compliance</b>	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.	<b>Not Applicable</b>	No recommendations were made by the committee to revise the case plans.
<b>At a minimum, the case staffing is attended by:</b>		
Local school district representative	<b>Compliance</b>	Each case staffing includes attendance by a local school district representative as required.
DJJ rep. or CINS/FINS provider	<b>Compliance</b>	A DJJ representative or CINS/FINS provider participates in each case staffing meeting in accordance with established guidelines.
<b>Other members may include:</b>		
State Attorney's Office	<b>Not Applicable</b>	Presence was not requested.
Mental health representative	<b>Compliance</b>	A mental health representative participates in case staffing meetings when applicable.
Substance abuse representative	<b>Not Applicable</b>	Presence was not requested.
Law enforcement representative	<b>Not Applicable</b>	Presence was not requested.
DCF representative	<b>Not Applicable</b>	Presence was not requested.
Others requested by youth/family	<b>Not Applicable</b>	Presence was not requested.
The program has an established case staffing committee, and has regular communication with committee members.	<b>Compliance</b>	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.	<b>Compliance</b>	Regular collaboration and communication with case staffing committee members are maintained to ensure coordinated planning and support for youth and families.

<b>Additional Comments:</b> There are no additional comments for this indicator.		
<b>3.6 - Adjudication Services: CINS Petition Process</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.6</b>		Yes Policy 3.6, Adjudication Services: CINS Petition Process, was last reviewed and approved 11/24/2025 by the Executive Director.
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.	<b>Not Applicable</b>	The program has not filed a CINS Petition during the review period.
Case Manager/Counselor completes a review summary prior to the court hearing.	<b>Not Applicable</b>	The program has not filed a CINS Petition during the review period.
<b>Additional Comments:</b> There are no additional comments for this indicator.		
<b>3.7 - Service Plan</b>		<b>Limited</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.7</b>		Yes Policy 3.7, Service Plan, was last reviewed and approved 11/24/2025 by the Executive Director.
A Case/Service Plan is developed within seven (7) working days of the youth's intake.	<b>Exception</b>	Three of five shelter files reviewed did not have evidence of the case plans being developed within seven days from the youth's intake.
A Case/Service Plan is developed within one contact following the completion of the NIRVANA.	<b>Exception</b>	In all five of the community counseling cases reviewed, the case service plan is not developed within one session after completion of the NIRVANA.
The plan is developed on a local provider approved form or through NETMIS based on information gathered during initial screening, intake, and NIRVANA.	<b>Compliance</b>	The Case/Service Plan is completed using approved provider forms or NETMIS, based on information from screening, intake, and NIRVANA.
<b>Youth and parents/guardians receive the following in writing</b>		
The Case/Service Plan reflects the individualized and prioritized needs and goals identified during the assessment process, including relevant domains from the NIRVANA.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Exception</b>	Of the 10 files reviewed, no files showed evidence of actual specific completion dates.
The signature of the youth is documented in the service plan.	<b>Compliance</b>	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.	<b>Compliance</b>	Parent/guardian signatures are obtained, reflecting engagement and shared responsibility in the service planning process.
If unavailable, the absence is documented with a reason on the plan.	<b>Compliance</b>	When a parent/guardian signature is unavailable, the absence is clearly documented with a stated reason, maintaining transparency and compliance.
The signature of the counselor is documented in the service plan.	<b>Compliance</b>	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.	<b>Exception</b>	Of the 10 files reviewed there is no evidence in six of the records showing the licensed mental health professional signed off of the initial plan within 7 days.
The date of plan initiation is clearly indicated.	<b>Exception</b>	There was no evidence of a clear initiation date of the service plan in two of the 10 files reviewed.
<b>The Case/Service Plan is formally reviewed and revised in collaboration with the youth and parent(s)/guardian(s)</b>		
At, 30 Days, following plan initiation:	<b>Exception</b>	One of three applicable shelter files reviewed was missing evidence of a 30 day review. Of the five community counseling files reviewed, the 30 day reviews were not completed within 30 days in all five files.
At, 60 Days, following plan initiation:	<b>Exception</b>	Of the five community counseling files reviewed, three of the files reviewed did not show evidence of a 60 day review completed within 60 days.
At, 90 Days, following plan initiation:	<b>Exception</b>	One applicable community counseling file did not show evidence of the 90 day review.

For court ordered youth, every six (6) months thereafter, or more frequently as needed to reflect changes in progress, needs, or service delivery.	<b>Not Applicable</b>	There were no eligible court-ordered youth during the review period.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>3.8 - Youth Records</b>	<b>Satisfactory</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.8</b>	Yes	
	Policy 3.8, Youth Records, was last reviewed and approved 11/24/2025 by the Executive Director.	
All records are marked “confidential”.	<b>Compliance</b>	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.	<b>Compliance</b>	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”.	<b>Compliance</b>	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.	<b>Compliance</b>	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"> <li>1. Table of Contents that outlines documents in each section</li> <li>2. Screening</li> <li>3. Informed Consent</li> <li>4. Photograph of the youth</li> <li>5. Shelter Intake Form</li> <li>6. Suicide Assessment (if needed)</li> <li>7. NIRVANA Self Report (NSR)</li> <li>8. NIRVANA full Assessment</li> <li>9. Plan of Service</li> <li>10. Chronological Notes</li> <li>11. Medication Inventory Form</li> <li>12. Approved contact list</li> <li>13. Copies of referrals made (if needed)</li> <li>14. Discharge summary once case is closed.</li> </ol>	<b>Compliance</b>	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.

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<p>COMMUNITY COUNSELING FILES</p> <ol style="list-style-type: none"> <li>1. Table of Contents that outlines documents in each section</li> <li>2. Screening</li> <li>3. Informed Consent</li> <li>4. Community Counseling Intake Form</li> <li>5. Suicide Assessment (if needed)</li> <li>6. NIRVANA full Assessment</li> <li>7. Plan of Service</li> <li>8. Chronological case notes</li> <li>9. Copies of referrals made (if needed)</li> <li>10. Discharge summary once the case is closed</li> </ol>	<p><b>Compliance</b></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><b>Compliance</b></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><b>Compliance</b></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><b>Additional Comments: There are no additional comments for this indicator.</b></p>		
<p><b>3.10 - Discharge and Follow Up</b></p>		<p><b>Limited</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 3.10</b></p>		<p>Yes</p>
		<p>Policy 3.10, Discharge and Follow Up, was last reviewed and approved 11/24/2025 by the Executive Director.</p>
<p>30 day follow-ups are provided post discharge for all youth served.</p>	<p><b>Exception</b></p>	<p>Of the 10 files reviewed, three of the files reviewed did not show evidence of a 30 day post follow up.</p>
<p>60 day follow-ups are provided post discharge for all youth served.</p>	<p><b>Exception</b></p>	<p>Of the 10 files reviewed, two of the files did not have evidence of a 60-day post discharge follow up.</p>
<p>Each file contains a discharge summary that describes the reason for termination.</p>	<p><b>Compliance</b></p>	<p>Discharge summaries clearly described the reason for termination, confirming appropriate closure of services and alignment with client progress.</p>
<p>Each file contains a discharge summary that outlines the events of the case, services provided, and progress of the youth and family.</p>	<p><b>Compliance</b></p>	<p>Each discharge summary outlined key case events, services provided, and measurable progress made by the youth and family throughout service delivery.</p>

<p>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.</p>	<p><b>Compliance</b></p>	<p>All discharge summaries documented the youth’s living arrangements at termination. For youth not returning home, the file included the reasons for alternative placement, plans for ongoing stability, and goals supporting future reunification when appropriate.</p>
<p>Each file contains a discharge summary that outlines the aftercare recommendations and the arrangements for case follow-up.</p>	<p><b>Compliance</b></p>	<p>Discharge summaries detailed aftercare recommendations and follow-up arrangements, ensuring continuity of care and resource connection beyond program exit.</p>
<p>Each file contains a NIRVANA Post Assessment.</p>	<p><b>Exception</b></p>	<p>Of the 10 files reviewed, all five shelter files did not have evidence of a NIRVANA post assessment.</p>
<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><b>Not Applicable</b></p>	<p>None of the 10 records reviewed were referred by the Truancy Court.</p>
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>		
<p><b>Domain Five</b></p>		
<p><b>5.0 - Shelter Program Services</b></p>		<p><b>Satisfactory with Exception(s)</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 5.0</b></p>		<p>Yes Policy 5.0, Shelter Program Services, was last reviewed and approved 11/24/25 by the Executive Director.</p>
<p>Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal.</p>	<p><b>Compliance</b></p>	<p>Youth are engaged in meaningful, structured activities seven days a week during awake hours, minimizing idle time and promoting positive development.</p>
<p>At minimum one hour of physical activity is provided daily.</p>	<p><b>Compliance</b></p>	<p>A minimum of one hour of physical activity is provided to youth each day as part of the daily schedule.</p>

<p>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.</p>	<p><b>Compliance</b></p>	<p>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.</p>
<p>Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read.</p>	<p><b>Compliance</b></p>	<p>Daily programming includes scheduled time for homework completion, access to age-appropriate reading materials, and opportunities for quiet reading and learning.</p>
<p>Daily programming schedule is publicly posted and accessible to both staff and youth.</p>	<p><b>Compliance</b></p>	<p>The daily programming schedule is clearly posted in a public area and accessible to both staff and youth.</p>
<p>Formal and accessible grievance procedures for youth, including available grievance forms and a locked box, is accessible to youth in a common area.</p>	<p><b>Compliance</b></p>	<p>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.</p>
<p>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.</p>	<p><b>Exception</b></p>	<p>The grievance box is being checked regularly but is not documented as such in the log book. Some of the logbook entries indicate there are no grievances but it is not clearly documented when the grievance box is "checked". A total of sixteen grievances were reviewed.</p>
<p>Only the Program Director/Supervisor has access to and manages grievances unless it is toward themselves (which are escalated to higher leadership).</p>	<p><b>Compliance</b></p>	<p>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.</p>
<p>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.</p>	<p><b>Exception</b></p>	<p>Sixteen total grievances were reviewed. There were no grievances in June, July, and October. Grievance dated 3/17/25 was not resolved until 3/26/2025 a total of 9 days from the day the grievance was submitted. Three grievances (dated 2/18/2025, 4/7/2025, and 5/4/25) used language that suggested the resolution would happen in the future (for example, "will speak with staff") and not at the time in which the grievance was signed as being resolved.</p>
<p>Grievances are maintained on file for a minimum of one (1) year.</p>	<p><b>Compliance</b></p>	<p>Grievances are securely maintained on file for a minimum of one (1) year in accordance with program policy.</p>
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>		

5.1 Shelter Environment		Satisfactory with Exception(s)
Provider has a written policy and procedure that meets the requirement for Indicator 5.1		Yes
		Policy 5.1, Shelter Environment, was last reviewed and approved 11/24/25 by the Executive Director.
The facility is clean, neat, and well-maintained.	Compliance	The facility is consistently clean, neat, and well-maintained throughout all areas.
Furnishings are in good repair.	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).	Compliance	Interior spaces are free from contraband or hazardous unauthorized materials, including metal or foreign objects.

<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><b>Compliance</b></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><b>Compliance</b></p>	<p>Material Safety Data Sheets (MSDS) are maintained and accessible for every approved chemical.</p>
<p>Washer/dryer are operational &amp; general area/lint collectors are cleaned after ever load.</p>	<p><b>Compliance</b></p>	<p>Washers and dryers are operational, and lint collectors are cleaned after each use.</p>
<p>Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket.</p>	<p><b>Compliance</b></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><b>Compliance</b></p>	<p>Youth have access to a secure, lockable space for personal belongings upon request.</p>
<p><b>Fire Safety</b></p>		
<p>Annual facility fire inspection was conducted and the facility is in compliance with local fire marshal and fire safety code within jurisdiction.</p>	<p><b>Compliance</b></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><b>Exception</b></p>	<p>1st Shift: Missed Fire Drill in October and on 8/5/25, the evacuation for the fire drill was 5 minutes. 2nd Shift: Missed fire drill in November On the 3rd Shift on 10/22/25, fire drill evacuation lasted 5 minutes.</p>
<p>Completes 1 mock emergency drill per shift quarterly, at a minimum.</p>	<p><b>Exception</b></p>	<p>1st Shift: No emergency drills 2nd Shift: No emergency drills since January 30, 2025 3rd Shift: No emergency drills since January 25, 2025</p>

<p>All annual fire safety equipment inspections are valid and up-to-date (building extinguishers, sprinklers, alarm system, kitchen overhead hood, and fire extinguishers in all vehicles). **Fire extinguishers should be easily accessible in the event of an emergency; not locked away.</p>	<p><b>Compliance</b></p>	<p>All fire safety equipment extinguishers, sprinklers, alarms, kitchen hood systems, and vehicle extinguishers, has current inspection tags and is easily accessible in case of emergency.</p>
<p>Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health.</p>	<p><b>Compliance</b></p>	<p>The facility maintains a current, satisfactory Residential Group Care inspection report from the Department of Health.</p>
<p>Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually.</p>	<p><b>Compliance</b></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.</p>	<p><b>Compliance</b></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><b>Compliance</b></p>	<p>Refrigerators and freezers are clean, maintain required temperatures, and all appliances are operational and sanitary.</p>
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>		
<p><b>5.2 - Shelter Search Policy</b></p>	<p><b>Satisfactory</b></p>	
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 5.2</b></p>	<p>Yes Policy 5.3, Logbook Requirements, was last reviewed and approved 11/24/25 by the Executive Director.</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><b>Compliance</b></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><b>Compliance</b></p>	<p>Shelter staff conduct searches of outdoor recreational areas before youth access the space to ensure safety and remove potential hazards.</p>
<p>Shelter staff conduct frequent and random searches on each shift.</p>	<p><b>Compliance</b></p>	<p>Shelter staff perform frequent and random searches during each shift to maintain a secure and controlled environment.</p>
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>		

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<b>5.3 - Logbook Requirements</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 5.3</b>		Yes Policy 5.3, Logbook Requirements, was last reviewed and approved 11/24/25 by the Executive Director.
<b>Data sources Reviewed</b>	<b>Dates Reviewed</b>	<b>Logbook Format</b>
Physical Logbook Girls Wing and Boys Wing in separate logs	6/6/2025 - 6/20/2025, 7/6/2025 - 7/20/2025, 8/1/2025 - 8/14/2025, 9/1/2025 - 9/14/2025, 10/6/2025 - 10/20/2025, 11/1/2025 - 11/14/2025	Paper Log
The program has a process in place to document daily activities, events, and other major occurrences.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	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	<b>Compliance</b>	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.	<b>Compliance</b>	Recording errors are corrected by striking through with a single line and including the staff's 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.	<b>Compliance</b>	White-out is not used, and all entries are made in ink with no erasures or alterations.
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.	<b>Compliance</b>	At the beginning of each shift, the oncoming supervisor and shelter counselor review prior log entries and document the review with a dated and signed entry.
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.	<b>Compliance</b>	All direct care staff review the logbook at the start of each shift for at least the previous two shifts and document the review with dates and signatures.

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.	<b>Compliance</b>	The program director or designee reviews the facility logbook weekly, documenting the review with the date, signature, and any necessary follow-up or recommendations.
Supervision and resident counts are documented.	<b>Compliance</b>	Supervision and resident counts are consistently documented.
Visitation and home visits are documented.	<b>Compliance</b>	Visitation and home visits are clearly documented.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>5.4 - Staffing Standards and Enhanced Supervision</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 5.4</b>		Yes
		Policy 5.4, Staffing Standards and Enhanced Supervision, was last reviewed and approved 11/24/25 by the Executive Director.
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.	<b>Compliance</b>	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.
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.	<b>Compliance</b>	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.
The shelter has implemented policies and procedures to ensure youth safety when being supervised by staff of the opposite sex.	<b>Compliance</b>	The shelter has implemented and follows clear policies and procedures to ensure youth safety when supervised by staff of the opposite sex.
The program staff schedule is provided to staff or posted in a place visible to staff.	<b>Compliance</b>	Staff schedules are provided and/or posted in a visible location to ensure adequate coverage and awareness of staffing assignments.
There is a holdover overtime rotation roster that includes home telephone numbers of staff who may be available when additional coverage is needed.	<b>Compliance</b>	A holdover and overtime rotation roster is maintained and includes contact information for staff available to provide additional coverage as needed.
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.)	<b>Compliance</b>	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.

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.	<b>Compliance</b>	The program assigns specific staff each shift to monitor the location, behavior, and movement of youth on enhanced supervision, with assignments documented in both the shelter log and staff calendar.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>5.5 - Behavior Management Strategies</b>	<b>Satisfactory</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 5.5</b>	Yes	
	Policy 5.5, Behavior Management Strategies, was last reviewed and approved 11/24/25 by the Executive Director.	
<b>A Behavior Management Strategy (BMS) is in place:</b>		
The program has a detailed written description of the BMS and it is explained during program orientation.	<b>Compliance</b>	The program maintains a detailed written description of its Behavior Management Strategy (BMS), which is reviewed with youth during program orientation.
<b>The written description of the behavioral management strategies include:</b>		
A wide variety of positive incentives used by the program.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	Behavioral interventions are applied immediately, consistently, and proportionate to the severity of the behavior.
<b>The Behavior Management Strategy includes:</b>		
Consequences for violation of program rules are applied logically and consistently.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	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.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>5.6 - Program Orientation</b>	<b>Satisfactory</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 5.6</b>	Yes	
	Policy 5.6, Program Orientation, was last reviewed and approved 11/24/25 by the Executive Director.	
<b>A total of five Program Orientation file(s) were reviewed during this evaluation period. Of these, two were open and three were closed.</b>		
<b>During the first 24 hours following admission, the program must begin the orientation process, to include:</b>		
Youth received a comprehensive orientation and handbook provided within 24 hours.	<b>Compliance</b>	Youth receive a comprehensive orientation and handbook within the first 24 hours of admission in accordance with program policy.
<b>Orientation includes the following:</b>		
Youth is given a list of contraband items	<b>Compliance</b>	Youth are provided with a list of contraband items and understand restrictions for safety and security.
Behavioral Expectations and a review of the BMS	<b>Compliance</b>	Behavioral expectations are reviewed in detail, including an explanation of the program’s Behavior Management Strategy (BMS).
Dress code explained	<b>Compliance</b>	The program’s dress code is explained to youth during orientation.
Review of access to medical and mental health services	<b>Compliance</b>	Youth are informed of available medical and mental health services and how to access them.
Procedures for visitation, mail and telephone	<b>Compliance</b>	Procedures for visitation, mail, and telephone use are reviewed with youth during orientation.

Grievance procedure	<b>Compliance</b>	The program’s grievance procedure is explained, including how to file a grievance and access grievance forms.
Disaster preparedness instructions	<b>Compliance</b>	Youth receive disaster preparedness instructions and understand emergency procedures.
Physical layout of the facility	<b>Compliance</b>	Youth are oriented to the physical layout of the facility, including key safety areas and exits.
Sleeping room assignment and introductions	<b>Compliance</b>	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	<b>Compliance</b>	Youth receive suicide prevention information, including how to alert staff if they or others experience suicidal thoughts.
Review of program schedule	<b>Compliance</b>	The daily program schedule is reviewed with youth to promote understanding of structure and expectations.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>5.7 - Youth Room Assignment</b>	<b>Satisfactory</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 5.7</b>	Yes	
	Policy 5.6, Program Orientation, was last reviewed and approved 11/24/25 by the Executive Director.	
<b>A total of five Youth Room Assignment file(s) were reviewed during this evaluation period. Of these, two were open and three were closed.</b>		
Review of youth’s history, status & exposure to trauma	<b>Compliance</b>	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	<b>Compliance</b>	Staff make collateral contacts, as needed, to gather additional information relevant to youth classification and safety.
Initial interactions with and observations of the youth	<b>Compliance</b>	Initial interactions and staff observations of the youth are used to inform room assignments and supervision levels.
Separation of younger youth from older youth	<b>Compliance</b>	Younger youth are housed separately from older youth to promote safety and developmental appropriateness.
Separation of violent youth from non-violent youth	<b>Compliance</b>	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	<b>Compliance</b>	Youth identified as susceptible to victimization are assigned rooms that promote protection and increased supervision.
Presence of medical, mental, or physical disabilities	<b>Compliance</b>	Youth with medical, mental health, or physical disabilities are appropriately classified to ensure their needs are safely accommodated.
Suicide risk	<b>Compliance</b>	Youth are screened for suicide risk upon admission, and any identified concerns are addressed immediately through safety planning and supervision.

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Sexually aggressive and predatory behavior	<b>Compliance</b>	Youth exhibiting sexually aggressive or predatory behaviors are identified and separated to maintain the safety of others.
Acute health symptoms requiring quarantine or isolation	<b>Compliance</b>	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.	<b>Compliance</b>	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.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>5.8 - Video Surveillance</b>	<b>Satisfactory with Exception(s)</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 5.8</b>	Yes	
	Policy 5.8, Program Orientation, was last reviewed and approved 11/24/25 by the Executive Director.	
<b>The agency has a system in operation 24 hours a day, 7 days a week. Does it demonstrate:</b>		
A written notice that is conspicuously posted on the premises for the purpose of security.	<b>Compliance</b>	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).	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	Cameras are not placed in bathrooms or sleeping quarters, ensuring the privacy and dignity of youth and staff.
System can capture and retain video photographic images which must be stored for a minimum of 30 days.	<b>Compliance</b>	The video surveillance system captures and retains recordings for a minimum of 30 days in compliance with program requirements.
System can record date, time, location and maintain resolution that enables facial recognition.	<b>Compliance</b>	The system records date, time, and location, maintaining sufficient resolution to enable facial recognition when needed.
Cameras can operate during a power outage.	<b>Compliance</b>	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).	<b>Compliance</b>	A current list of designated personnel authorized to access the surveillance system, including off-site access permissions, is maintained and up to date.

<p>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 random sample of overnight shifts.</p>	<p style="text-align: center;"><b>Exception</b></p>	<p>There is a lack of evidence to support supervisors regularly reviewed the camera until October of 2025 where the current shelter manager transitioned into the interim leadership role. Since stepping into that role, supervisor reviews of the camera system is clearly documented in the "supervisor camera review" logbook.</p> <p>On 6/1 and 6/14 it is documented that the program director completed the camera review but in the narrative only 6/14 and 6/28 were documented. This discrepancy in documentation makes it unverifiable for 6/1.</p> <p>Reviewer was unable to verify camera review was completed in August because the note that indicates when camera review was done on 8/21 from 3-5am did not correspond with supervisor's notes written on the 6th and the 19th.</p> <p>There was only one camera review completed in the month of September, on 9/11 from 4am to 6am.</p>
<p>Requests for video recordings pursuant to investigations or quality improvement visits are provided within 24-72 hours of the request.</p>	<p style="text-align: center;"><b>Compliance</b></p>	<p>Video recordings requested for investigations or quality improvement purposes are provided within 24–72 hours of the request.</p>
<p>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.</p>	<p style="text-align: center;"><b>Compliance</b></p>	<p>Service requests for malfunctioning or inoperable cameras are submitted within 24 hours of discovery, and documentation of repair efforts is maintained for quality assurance.</p>
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>		
<p><b>Domain Six</b></p>		
<p><b>6.0 - Medication Management and Distribution</b></p>	<p style="text-align: center;"><b>Satisfactory</b></p>	
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 6.0</b></p>	<p>Yes</p> <p>Policy 6.0, Medication Management and Distribution, was last reviewed and approved 11/24/25 by the Executive Director.</p>	

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<p><b>A total of four Medication Management and Distribution file(s) were reviewed during this evaluation period. Of these, two were open and two were closed.</b></p>		
<p>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.</p>	<p><b>Compliance</b></p>	<p>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.</p>
<p>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</p>	<p><b>Compliance</b></p>	<p>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>
<p>There is evidence of, at least, quarterly staff meetings conducted by RN and/or Shelter Manager to:                      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>	<p><b>Compliance</b></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><b>Compliance</b></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><b>Compliance</b></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><b>Compliance</b></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><b>Compliance</b></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><b>Compliance</b></p>	<p>Staff responsible for three errors within a one-year period have their certification suspended and are recertified only after completing full in-person training and competency evaluation by an RN.</p>
<p>All medications (included narcotics and controlled medications) are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth.</p>	<p><b>Compliance</b></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: (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>	<p><b>Compliance</b></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><b>Compliance</b></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><b>Compliance</b></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><b>Compliance</b></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><b>Compliance</b></p>	<p>Medication refrigeration units are consistently maintained at 2–8°C (36–46°F) to meet temperature requirements.</p>

Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics).	<b>Compliance</b>	Only authorized staff listed in User Permissions have access to secured medications, with restricted access to controlled substances.
Perpetual inventory with running balances are maintained for controlled substances.	<b>Compliance</b>	Controlled substances are tracked through a perpetual inventory system maintaining real-time running balances.
Shift-to-shift counts (verified by a witness and is documented) are conducted and documented for controlled substances.	<b>Compliance</b>	Shift-to-shift counts of controlled substances are conducted and documented by two staff members to ensure accuracy and accountability.
Non-controlled medication and over-the-counter medications that are accessed regularly are inventoried weekly.	<b>Compliance</b>	Regularly accessed non-controlled and over-the-counter medications are inventoried weekly to ensure proper tracking.
Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly.	<b>Not Applicable</b>	Per the shelter manager, there were no medical sharps to inventory during the review period.
There are monthly reviews of Pyxis Reports to monitor medication management practice.	<b>Compliance</b>	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 (nurse or trained/certified staff) 2. Registered Nurse or Licensed Practical Nurse (nurse only) 3. Pill Identifier (Pill Finder) – Drugs.com (nurse or trained/certified staff)	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	The medication delivery process fully aligns with Florida Network’s Medication Management and Distribution Policy.
All discrepancies are cleared each shift.	<b>Compliance</b>	All medication discrepancies are identified, reviewed, and cleared at the end of each shift.

<p>Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a) TOP COVER b) BACK PANEL- LEFT TALL CABINET LOCK- LEFT c) BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT</p>	<p><b>Compliance</b></p>	<p>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.</p>
<p>A Medication Distribution Log is used for the distribution of medication by non-licensed and licensed staff.</p>	<p><b>Compliance</b></p>	<p>A Medication Distribution Log is consistently used by both licensed and non-licensed staff to record the administration of all medications.</p>
<p>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.</p>	<p><b>Compliance</b></p>	<p>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.</p>
<p>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.</p>	<p><b>Compliance</b></p>	<p>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>
<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><b>Compliance</b></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><b>Compliance</b></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><b>Additional Comments:</b> On 12/3/25 at 3:20pm, a medication pass was observed during the QI Review. The shelter supervisor called the youth to the medication door. After cleansing hands with hand sanitizer, the supervisor then handed the youth a cup of water and asked the youth to state the name of her medication, its purpose, and its color. Supervisor then accessed the medication from the Pyxis and administered it to said youth. Youth subsequently signed for the medication.</p>		

<b>6.1 - Naloxone Administration and Opioid Overdose Response</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 6.1</b>		Yes
		Policy 6.1, Naloxone Administration and Opioid Overdose Response, was last reviewed and approved 11/24/25 by the Executive Director.
Naloxone is stored between 37 and 77 degrees F and is stored with a cold pack when transported in vehicles to maintain effectiveness.	<b>Compliance</b>	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.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>6.2 - Suicide Prevention</b>		<b>Failed</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 6.2</b>		Yes
		Policy 6.2, Suicide Prevention, was last reviewed and approved 11/24/25 by the Executive Director.
<b>Shelter maintains a written suicide prevention &amp; response plan approved by the Florida Network.</b>		Yes
<b>SNAP maintains a written suicide prevention &amp; response plan approved by the Florida Network.</b>		N/A
<b>Community Counseling maintains a written suicide prevention &amp; response plan approved by the</b>		Yes
Core Requirements All Programs: Upon intake, every youth is screened for suicidality using the five Florida Network questions.	<b>Exception</b>	The program's current policy has the correct five suicide risk questions. However, six youth charts were reviewed and all six youth charts are using an outdated CINS/FINS Intake Assessment Form / Suicide Risk Screening.
Core Requirements All Programs: Screening results are reviewed, signed by a supervisor, and filed in the youth's case record.	<b>Compliance</b>	Screening results are promptly 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.	<b>Compliance</b>	Any positive response immediately triggers a full suicide risk assessment 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.	<b>Exception</b>	Six youth charts were reviewed and five out of the six youth charts do not have the LMHP signing the Youth Suicide Risk Assessment within 24 hours.

<p>Core Requirements (All Programs) 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.</p>	<p><b>Exception</b></p>	<p>Six youth charts were reviewed and two out of the six youth charts had no evidence of a follow-up or proper follow up assessment documentation. Two of three shelter youth were not placed on Constant Sight or Sound even though they checked 'yes' to the Suicide Risk Screening question(s).</p>
<p>Core Requirements (All Programs) If conducted by a non-licensed staff member, the LMHP must co-sign and date as reviewer the next time they are on-site.</p>	<p><b>Exception</b></p>	<p>Six youth charts were reviewed and one out of the six youth charts did not have the LMHP signing the Youth Suicide Risk Assessment at all.</p>
<p>Core Requirements (All Programs) 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.</p>	<p><b>Exception</b></p>	<p>Upon review of the safety plan dated 8/13/25, it was noted that the parental signature line was left unsigned by the parent.</p>
<p>Core Requirements (All Programs) If a youth poses an immediate threat to self or others at any time, staff follow Baker Act protocols and/or call 911.</p>	<p><b>Compliance</b></p>	<p>Staff respond appropriately to any immediate threats by following Baker Act protocols or contacting emergency services as required.</p>
<p><b>Documentation &amp; Family Notification</b></p>		
<p>All screenings, assessments, supervision actions, and shift-to-shift handoffs are logged in the daily shelter/counseling logbook.</p>	<p><b>Compliance</b></p>	<p>All screenings, assessments, and supervision activities, including shift-to-shift handoffs, are clearly recorded in the daily logbook.</p>
<p>If a guardian cannot be reached in person, telephone contact attempts are documented; and written notice is sent by certified mail.</p>	<p><b>Not Applicable</b></p>	<p>Parent notification was observed for all six youth charts reviewed.</p>

<p>When an immediate assessment is not possible, families receive community resource information.</p>	<p><b>Not Applicable</b></p>	<p>All six youth charts contained suicide assessments that were completed immediately.</p>
<p>Community Counseling Only: Any screening conducted on school property during school hours is reported to appropriate school authorities.</p>	<p><b>Exception</b></p>	<p>On 10/30/25 the youth was seen at their school and indicated "yes" to one of the Suicide Risk Assessment questions. However, the counselor did not notify school staff of the positive response before departing the school.</p>
<p>Residential Only: Youth with a positive suicide screen are placed on Constant Sight &amp; Sound Supervision until assessed by a licensed professional or non-licensed professional under the direct supervision of the licensed professional.</p>	<p><b>Exception</b></p>	<p>Two out of the three youth were not placed on constant sight and sound supervision despite having answered 'yes' to the questions on the Suicide Risk Screening question(s).</p>
<p>Residential Only: Youth placed on the appropriate level of supervision based on the results of the suicide risk assessment?</p>	<p><b>Exception</b></p>	<p>Two out of the three youth were not placed on the proper supervision based on the results of the Suicide Risk Screening.</p>
<p>Residential Only: Staff document observations (time, behavior notes, warning signs, initials) at intervals no longer than 30 minutes.</p>	<p><b>Exception</b></p>	<p>The proper observation documents were not started for two of the three of the youth that answered yes to the Suicide Risk Screening question(s).</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><b>Exception</b></p>	<p>The appropriate level of supervision for two of the three youth was never implemented.</p>
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>		

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<b>6.3 - Healthcare Admission Screening</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 6.3</b>		Yes
		Policy 6.3, Healthcare Admission Screening, was last reviewed and approved 11/24/25 by the Executive Director.
<b>A total of five Healthcare Admissions Screening file(s) were reviewed during this evaluation period. Of these, two were open and three were closed.</b>		
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.	<b>Compliance</b>	The nurse completes the primary healthcare screening when present at intake, or reviews it within three business days if not on-site.
<b>The primary healthcare screening and observations include:</b>		
Current medications	<b>Compliance</b>	The primary healthcare screening includes verification and documentation of all current medications.
Existing (acute and chronic) medical conditions	<b>Compliance</b>	Existing acute and chronic medical conditions are accurately identified and recorded.
Allergies	<b>Compliance</b>	Any allergies are clearly documented during the screening process.
Recent injuries or illnesses	<b>Compliance</b>	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.	<b>Compliance</b>	Staff document careful observations for signs of illness, injury, pain, physical distress, or mobility difficulties.
Acute health symptoms requiring quarantine or isolation	<b>Compliance</b>	Youth exhibiting symptoms requiring quarantine or isolation are promptly identified, and appropriate protocols are followed.
Parents are involved with the coordination and scheduling of follow-up medical appointments, as appropriate.	<b>Compliance</b>	Parents and guardians are engaged in coordinating and scheduling follow-up medical appointments as needed.
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.	<b>Compliance</b>	The program's policy and procedures include a protocol and system for making medical referrals and follow-ups for youth admitted with chronic medical conditions.
All medical referrals are documented on a daily log.	<b>Compliance</b>	Medical referrals are documented in the program logbook.
<b>Additional Comments: There are no additional comments for this indicator.</b>		

<b>6.4 - Medical/Mental Health Alert Process</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 6.4</b>		Yes
		Policy 6.4, Medical/Mental Health Alert Process, was last reviewed and approved 11/24/25 by the Executive Director.
<b>A total of five Medical/Mental Health Alert Process file(s) were reviewed during this evaluation period. Of these, two were open and three were closed.</b>		
If youth has a medical or mental health condition or allergies, they are appropriately placed on the program’s alert system.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	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.
<b>Additional Comments: There are no additional comments for this indicator.</b>		