



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

Crosswinds Youth Services, Inc.

1407 Dixon Blvd.
Cocoa, FL 32922

January 7-8, 2026

Compliance Monitoring Services Provided by



EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the Crosswinds Youth Services, Inc. for the FY 2025-2026 at its program office located at 1407 Dixon Boulevard, Cocoa, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic, and overall contract requirements. Crosswinds Youth Services 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 Crosswinds Youth Services present for the entrance interview were: Michael Scully, Karen Locke, Tara Lonergan, Shannon Wilson, Pierre Bando, Cindi Lee, John Weiman, Donna Stokes, Cherish Lawson, Rikki Lea Krupezek, Myrna Peterson, Jennifer Erfurth, Dawn Blustain, Sevonte Miller, Rachel Doucette, Louis Hill, Alexis Kirkpatrick, and Marva Young. The last onsite QI visit was conducted on October 30-31, 2024.

In general, the Reviewer found that Crosswinds Youth Services is in compliance with specific contract requirements. Crosswinds Youth Services **received an overall compliance rating of 100% for achieving full compliance with 13 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

2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 01-07-2025-2026

Agency Name: Crosswinds Youth Services, Inc.					Monitor Name: Marcia Tavares, Lead Reviewer		
Contract Type: CINS/FINS					Region/Office: 1407 Dixon Boulevard Cocoa, FL 32922		
Service Description: Comprehensive Onsite Compliance Monitoring					Site Visit Date(s): January 7-8, 2026		
Major Programmatic Requirements	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable:
	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable		
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Crosswinds Youth Services currently has two certified Peer Reviewers, Pierre Bando and Cindi Lee. Both staff have participated in at least one QI review during the past 12-month period.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: A list of 5 additional contracts for FY2025 was provided. The provider receives funding from Family Partnerships of Central Florida, the Department of Health and Human Services, the Brevard County Board of County Commissioners, and United Way.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of \$100,000 per accident, \$100,000 per person and \$500,000 policy aggregate. Commercial General Liability with a limit of \$500,000 per occurrence, and \$1,000,000 policy aggregate. Automobile Liability Insurance shall be	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Commercial General Liability through Wesco Insurance Company, for limits of coverage \$1,000,000 each \$3,000,000 aggregate and medical expense \$5000, effective 10/21/25-10/21/26. Workers Compensation through Technology Insurance Company with	

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required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of \$250,000 per person; with a minimum limit for bodily injury of \$500,000 per accident; with a minimum limit for property damage of \$100,000 per accident and with a minimum limit for medical payments or \$5,000-\$10,000 per person. Florida Network is listed as payee or co-payee. PTV						limits of \$100,000 for each accident/each disease-each employee, and policy limit \$500,000. effective 5/1/25-5/1/26. Automobile insurance through Wesco Insurance Company, for combined single limits of \$1,000,000 effective 10/21/25-10/21/26. Florida Network is listed on the Insurance Certificate as the certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	The agency has no external corrective action plans from any other funding source.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Fiscal Policies and Procedures are contained in the agency's Accounting Procedures Manual. The procedures reviewed appear to be consistent with GAAP and provide limited internal controls. Procedures are included for: general accounting procedures, cash	

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Major Programmatic Requirements	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable		
						management procedures, accounts receivable, payroll, property, plant, and equipment procedures, accounts payable; procedures for liability, and management reporting. The agency maintains fiscal files that are audit ready in its business finance office.	
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Detailed General Ledger for the current FY, for the period July – December 2025. The agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS program. The GL includes the following items: distribution account, type of transaction, date, funder account name, memo, split, amount, and balance.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) – ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Observation/Documentation: Reviewed petty cash Policy and Procedure, last revised August 2022. The shelter recreation cash fund does not exceed \$600. The shelter manager	

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						is the custodian of the funds that are disbursed by the finance office.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation and documentation provided contained 2 signatures. (Disbursements/invoices are approved & monitored by management). ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reviewed Bank Statements and Bank Reconciliations for June - November 2025 for the program's Operating account held with Bank of America. Bank reconciliations are conducted by the Finance Manager each month for the activities and bank statements for the preceding month. The bank statements were all found to be reconciled consistently within six weeks of receipt. Invoices are submitted monthly with supporting documentation.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over \$1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. PTV/ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	The agency does not have an inventory, including computers, over \$1000 requiring a DJJ property inventory number/ tag.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), <u>Employee</u> IRS Form W-2 and <u>Independent Contractors</u> IRS Form 1099 forms prior to federal requirements. ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: The agency provided their two most recent quarterly tax filing activity reports as proof of Federal tax form 941 submission. A review of the tax reports and payments for quarters	

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						ending 6/30/25 and 09/30/2025 was conducted and provided evidence they were prepared, managed, and submitted by a third-party payroll company, Paycor. Employee IRS W-2 and 1099 forms are all produced and managed by Paycor.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. PTV/ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: The FY to date 25-26 budget to actual report was reviewed. It is prepared by the Director of Finance and reviewed by the CEO. Variances are tracked daily and compared with the census. Adjustments are made daily to account for variances. All variances are reported to the Board of Directors directly at monthly Board Meetings.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than \$750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. Can obtain from FNYFS	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H & Co. LLP is the accounting firm hired that completed the agency's audit as of June 2023, per letter dated December 5, 2025. Per the single audit, there are no findings and questioned costs to be reported, and a management letter is not issued. A copy of the audit is on file with the Reviewer.	

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i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: The agency has policies and procedures to ensure the security and privacy of all employees and client data is maintained. Personal information is not easily accessible, and the agency maintains a backup system in case of accidental loss of financial information. There are security procedures in place to protect laptops. Documents and computer hard drives are properly destroyed/ wiped prior to disposal.	
j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least \$19.00 per hour. This also includes funding for additional staff as approved by the Department. ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: The agency provided the most recent employee listing with pay rates for staff hired since the last contract monitoring. The pay rate listing provides documentation to support direct care employees earn at least \$19.00 per hour.	

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Disaster Planning k. The agency has a written policy and procedure that includes a policy title/number, date of last review/revision, meets all of the requirements for the indicator that has been approved. The agency has a comprehensive Disaster Preparedness Plan that includes the following: <ul style="list-style-type: none"> o Emergency evacuation protocols o Severe weather procedures o Evacuation logistics (shelter only) o Evacuation facility designation (shelter only) o Critical Resource Planning o Florida Network and DJJ notification requirements The Universal Agreement/Emergency Disaster Shelter document is signed by the agency executive. The comprehensive Disaster Preparedness Plan is submitted to the Florida Network annually, no later than February 1st. ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: The provider maintains an Emergency Disaster Plan for 2025 that includes a procedural guide in emergency situations. The most recent annual review of the plan was conducted on March 2, 2025. The Disaster Preparedness Plan includes the following: <ul style="list-style-type: none"> o Emergency evacuation protocols o Severe weather procedures o Evacuation logistics (shelter only) o Evacuation facility designation (shelter only) o Critical Resource Planning o Florida Network and DJJ notification requirements The Universal Agreement/Emergency Disaster Shelter document was signed by the agency executive.	

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CONCLUSION

Crosswinds Youth Services Inc. has met the requirements for the CINS/FINS contract as a result of full compliance with thirteen 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 corrective action items from external funders nor does it have any purchases (with FNYFS funds) greater than \$1000, requiring inventory or IRR requests. Consequently, **the overall compliance rate for this contract monitoring visit is 100%**. There are no recommendations or corrective actions required 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) 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 Crosswinds Youth Services, Inc. - Cocoa, Florida
CINS/FINS Program

Date: January 7-8, 2026

Compliance Monitoring Services Provided by



CINS/FINS Rating Profile

Domain 1: Background Screening and Compliance

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

Percent of indicators rated Satisfactory: 90 %
Percent of indicators rated Limited: 10 %
Percent of indicators rated Failed: 0 %

Domain 3: Screening, Assessment & Case Management

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

Percent of indicators rated Satisfactory: 87.5 %
Percent of indicators rated Limited: 12.5 %
Percent of indicators rated Failed: 0 %

Domain 4: SNAP® Programs

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

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

Domain 5: Shelter Program Services

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

Percent of indicators rated Satisfactory: 66.67 %
Percent of indicators rated Limited: 33.33 %
Percent of indicators rated Failed: 0 %

Domain 6: Medication Management

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

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 83.33 %
Percent of indicators rated Limited: 16.67 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
 Heather Molinario – Regional Monitor, Department of Juvenile Justice
 Jasmine Crayton - Youth and Family Advocates, RAP House
 Sabrina Childears - Seminole County Sheriff's Office
 Jean Christiansen-Goggin - Childrens Home Society -Treasure Coast

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

- | | | |
|--|--|--|
| <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Chief Executive Officer <input type="checkbox"/> Chief Financial Officer <input checked="" type="checkbox"/> Chief Operating Officer <input type="checkbox"/> Executive Director <input type="checkbox"/> Program Director <input checked="" type="checkbox"/> Program Manager <input type="checkbox"/> Program Coordinator <input checked="" type="checkbox"/> Clinical Director <input checked="" type="checkbox"/> Counselor Licensed | <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Case Manager <input type="checkbox"/> Counselor Non-Licensed <input type="checkbox"/> Advocate <input checked="" type="checkbox"/> Direct – Care Full time <input type="checkbox"/> Direct – Part time <input type="checkbox"/> Direct – Care On-Call <input type="checkbox"/> Intern <input type="checkbox"/> Volunteer <input checked="" type="checkbox"/> Human Resources | <ul style="list-style-type: none"> <input type="checkbox"/> Nurse – Full time <input checked="" type="checkbox"/> Nurse – Part time <input type="checkbox"/> 1 # Case Managers <input type="checkbox"/> 2 # Program Supervisors <input type="checkbox"/> # Food Service Personnel <input type="checkbox"/> 1 # Healthcare Staff <input type="checkbox"/> # Maintenance Personnel <input type="checkbox"/> 1 # Other (listed by title): <u>Compliance Administrator</u> |
|--|--|--|

Documents Reviewed

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Accreditation Reports <input checked="" type="checkbox"/> Affidavit of Good Moral Character <input checked="" type="checkbox"/> CCC Reports <input checked="" type="checkbox"/> Logbooks <input type="checkbox"/> Continuity of Operation Plan <input checked="" type="checkbox"/> Contract Monitoring Reports <input checked="" type="checkbox"/> Contract Scope of Services <input checked="" type="checkbox"/> Egress Plans <input type="checkbox"/> Fire Inspection Report <input type="checkbox"/> Exposure Control Plan | <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Table of Organization <input checked="" type="checkbox"/> Fire Prevention Plan <input checked="" type="checkbox"/> Grievance Process/Records <input type="checkbox"/> Key Control Log <input checked="" type="checkbox"/> Fire Drill Log <input checked="" type="checkbox"/> Medical and Mental Health Alerts <input checked="" type="checkbox"/> Precautionary Observation Logs <input checked="" type="checkbox"/> Program Schedules <input checked="" type="checkbox"/> List of Supplemental Contracts <input type="checkbox"/> Vehicle Inspection Reports | <ul style="list-style-type: none"> <input type="checkbox"/> Visitation Logs <input checked="" type="checkbox"/> Youth Handbook <input type="checkbox"/> 5 # Health Records <input type="checkbox"/> 6 # MH/SA Records <input type="checkbox"/> 12 # Personnel /Volunteer Records <input type="checkbox"/> 8 # Training Records <input type="checkbox"/> 15 # Youth Records (Closed) <input type="checkbox"/> 7 # Youth Records (Open) <input type="checkbox"/> # Other: ___ ___ |
|---|--|---|

Observations During Review

- | | | |
|--|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Intake <input checked="" type="checkbox"/> Program Activities <input type="checkbox"/> Recreation <input checked="" type="checkbox"/> Searches <input checked="" type="checkbox"/> Security Video Tapes <input type="checkbox"/> Social Skill Modeling by Staff <input checked="" type="checkbox"/> Medication Administration | <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Posting of Abuse Hotline <input type="checkbox"/> Tool Inventory and Storage <input checked="" type="checkbox"/> Toxic Item Inventory & Storage <input type="checkbox"/> Discharge <input type="checkbox"/> Treatment Team Meetings <input checked="" type="checkbox"/> Youth Movement and Counts <input checked="" type="checkbox"/> Staff Interactions with Youth | <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Staff Supervision of Youth <input checked="" type="checkbox"/> Facility and Grounds <input checked="" type="checkbox"/> First Aid Kit(s) <input checked="" type="checkbox"/> Group <input type="checkbox"/> Meals <input type="checkbox"/> Signage that all youth welcome <input type="checkbox"/> Census Board |
|--|---|---|

Surveys

- | | | |
|---------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> 6 # of Youth | <input type="checkbox"/> 8 # of Direct Staff | <input type="checkbox"/> # of Other |
|---------------------------------------|--|-------------------------------------|

January 7-8, 2026

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

Crosswinds Youth Services, Inc. is located at 1407 Dixon Blvd. Cocoa, Florida. The program serves Circuit 18, covering all of Brevard County. Services provided by the program include Children In Need of Services/Families In Need of Services (CINS/FINS) shelter, Community Counseling, Domestic Violence Respite, Probation Respite, and Stop Now And Plan (SNAP).

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

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 with Exception(s)

Indicator 1.3 Incident Reporting was rated Satisfactory with Exception(s)

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

Indicator 1.5 Data Entry & Collection was rated Satisfactory

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

Indicator 1.7 Client Transportation was rated Limited

Indicator 1.8 Client Contact was rated Satisfactory

Indicator 1.9 Outreach Services was rated Satisfactory

Domain 3: There are eight indicators for Domain 3.

Indicator 3.2 Admission Process was rated Limited

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

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

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

Indicator 3.6 Staffing and Youth Supervision was rated Satisfactory

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

Indicator 3.8 Youth Records was rated Satisfactory

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

January 7-8, 2026

Domain 4: There are five indicators for Domain 4.

Indicator 4.0 SNAP® Under 12 was rated Satisfactory

Indicator 4.1 SNAP® Fidelity Monitoring was rated Satisfactory

Indicator 4.2 SNAP® for Youth was rated Not Applicable

Indicator 4.3 SNAP® Youth Justice was rated Satisfactory with Exception(s)

Indicator 4.5 SNAP® for Schools and Communities was rated Satisfactory

Domain 5: There are five indicators for Domain 5.

Indicator 5.0 Shelter Program Services was rated Limited

Indicator 5.1 Shelter Environment was rated Limited

Indicator 5.2 Shelter Search Policy was rated Limited

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 with Exception(s)

Indicator 6.1 Naloxone Administration and Opioid Overdose Response was rated Satisfactory

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

Indicator 6.3 Healthcare Admission Screening was rated Limited

Indicator 6.4 Medical/Mental Health Alert Process was rated Satisfactory

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

Domain 1:

• 1.7 - Transportation of Youth: The program's policy requires weekly reviews of the transportation documentation; however, there were no transport documentation reviews located for the review period. Five of ten single transport incidents reviewed did not have parental consent documentation; one was a dependent youth without the consent form. Four of ten single transport incidents reviewed were not documented in the logbook, and the transport van log did not contain the information of approval or youth name. Four of ten single transport incidents reviewed were not documented in the logbook, hence, check-in documentation was missing.

Domain 3:

• 3.2 - Admission Process: Documentation of information provided to residential clients about possible actions through involvement in CINS/FINS was not found for all six residential client files reviewed. Non-Residential CINS/FINS Handbook includes information. Documentation for information provided was not found for six of the ten client files reviewed.

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Domain 5:

• 5.0 - Shelter Program Services: Twenty-three grievances that were submitted from July to December 1, 2025 were reviewed. Two of the 23 grievances were not resolved timely. The grievance submitted 8/30/25 was resolved 9/8/25, and one submitted on 10/21/25 did not have a resolution date. A review of logbook documentation for grievance box checks for the period of October 17 through October 31 shows inconsistent entries. No grievance box checks were documented on 10/20, 10/22, 10/23, and 10/24. Grievance box checks were documented on 10/21 for both 10/21 and 10/20. There was documentation the boxes were checked 10/29, 10/30, and 10/31. On 10/28, an entry was completed for that date and included a note indicating that staff checked for grievances from the previous day 10/27, rather than having a distinct entry for each day. Overall, while several days reflect proper documentation, there are gaps and inconsistencies that indicate the grievance box check logs were not completed consistently on a daily basis during this review period. For the period July 1, 2025, through January 8, 2026, a total of 135 grievance box checks were required to meet the Monday–Friday schedule. During this timeframe, only 57 grievance checks were documented.

• 5.1 - Shelter Environment: The program has two vans used to transport youth; however, one of the vans was not available for inspection as it was being serviced and held at the service shop. An inspection of the 2019 Honda Odyssey revealed the fire extinguisher in the vehicle was punched November 2024 and expired November 2025. Weekly count sheets for chemicals are completed consistently; however, a perpetual count log is not consistently maintained. Counts were only observed for the period from October 2, 2024, to November 15, 2024. During inspection of the chemicals, it was observed the MSDS for zep, bleach, and dawn were missing. The program obtained the documents during the review. The last annual Fire Inspection was conducted by Cocoa Fire Department on 12/3/2024, noting code violations. As of the QI visit, a current inspection was not completed. On 11/20/25, deficiencies were identified, including no audible sound, a damaged pull station, and an expired battery. Documentation was provided showing a change in service providers, transitioning from Wiginton to a new company for inspection and maintenance services. The annual fire inspection was delayed due to the pending repairs and work orders were submitted. The program reported the annual inspection will take place in January after repairs are completed. During the past six months, monthly fire drills were conducted on each shift as follows on 1st Shift: 7/21, 8/17, 9/23, 10/25, 11/22, and 12/23; 2nd Shift: 8/6, 9/3, 10/22, 11/26, and 12/21; and on 3rd Shift: 7/2, 8/2, 9/3, 10/8, 11/15, and 12/15. A review of fire drill documentation identified multiple instances of incomplete and non-compliant entries related to required time tracking and documentation standards. Not everyone evacuated on several dates for different reasons as follows: 7/2- due to safety (3rd shift); 7/21- page missing with number evacuated; 9/3 due to safety concerns (3rd shift); 10/8 due to safety concerns; 11/15 - due to lateness (3rd shift); and 12/15 - due to 3 youth being ill (3rd shift). Four drills were missing documented end times: 7/2 – 2nd shift, 8/2, 9/3 – 3rd shift, and 10/8. Evacuation time exceeded two minutes for four drills: 9/23, 11/22, 11/26, and 12/15. In November, a revised fire drill template was implemented, which included a reminder that the building must be cleared within two minutes or less. During this transition, there were entries where camera footage was reviewed and evacuation times were subsequently updated to reflect more accurate completion times. Additional documentation concerns were noted, including missing youth signatures on some fire drill logs and a lack of clarity regarding staff identification completing the drill documentation. There were three fire extinguishers dated 11/2024 which expired 11/2025, including one in the vehicle that was on site. Most recent Sanitation certificate inspection date was 12/11/2024. Per the program DOH will be inspecting at the end of the month.

• 5.2 - Shelter Search Policy: Environmental search checks were not observed in the documentation reviewed and there was no evidence recreational areas were searched prior to the use of outside spaces. Room search and contraband documentation was reviewed. Room search forms reflect an entry dated 6/25/25, with the next recorded entry not occurring until 12/25. Contraband documentation shows several entries in September, followed by no additional entries until 12/18. These gaps indicate inconsistent documentation during the review period.

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Domain 6:

• 6.3 - Healthcare Admission Screening : None of the five reviewed records contained documentation of the nursing staff's acknowledgement of the healthcare screening questions on the Residential Intake Form due to nurse vacancies. The program has had nursing vacancies throughout the review period as a result of decisive corrective actions to fully resolve multiple healthcare administration issues that were uncovered around medication errors. The CEO provided documentation to support the corrective actions that were implemented including personnel corrective actions for three youth specialists and the registered nurse, revision of the agency's healthcare administration policy and healthcare screening forms, revision of the nurses job description, request and fulfillment of an onsite program review and assessment by another provider's registered nurse, and onsite retraining of Crosswind staff by Florida Network's (FN) provided nurse. The CEO communicated and consulted the FN to define the best practices including recruitment and qualification of potential candidates and successfully filled the nurse position on December 16, 2025. None of the five reviewed records had documentation of nursing staff being present or reviewing the healthcare screening within three days. None of the five reviewed records had the youth's current medications listed on Intake Form as required.

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CINS/FINS QUALITY IMPROVEMENT TOOL		
<p>Quality Improvement Indicators and Results: Compliance: The findings observed or reviewed indicate the practice is aligned with the requirement(s) for the review item at the time of the review. Exception: The findings observed or reviewed indicate the practice is not aligned with the requirement(s) for the review item at the time of the review. Not Applicable: The item reviewed is not applicable for this review item(s) or the agency is not contracted to provide services related to the review item. E.g. If the agency has a policy that states they will not transport under any circumstance, Indicator 1.06 would be not applicable.</p>	<p>Summary/Narrative Findings: This column provides a comprehensive narrative summary of each assigned QI indicator. It highlights areas where the program demonstrated compliance, outlines the evidence supporting those determinations, and provides detailed explanations for any deficiencies or exceptions. Together, these findings offer clear justification for the specific domain ratings and present a balanced view of program performance.</p>	
Domain One – Background Screening and Compliance		
1.0 - Background Screening		
Provider has a written policy and procedure that meets the requirement for Indicator 1.0	Satisfactory	
Provider has implemented a Suitability Assessment policy and procedure that meets the requirement for Indicator 1.0	Yes	
	Yes	
	The agency has the required policy Section 100-1.0, Background Screening Requirements, that was approved 12/21/2025 by the COO. The provider utilizes the Berke Assessment pre-employment tool and has established a passing/hire score of medium or above.	
A total of 12 file(s) were reviewed during this evaluation period. Of these, 12 new hire file(s) and zero 5-year rescreen file(s) were reviewed. The sample included 12 employee(s) and zero volunteer(s).		
Suitability Assessment		
All positions providing direct services (residential and community counseling) to youth has successfully passed pre-employment suitability assessment on the initial attempt.	Compliance	All staff providing direct services to youth successfully passed the pre-employment suitability assessment on their initial attempt.
For any applicant that did NOT pass the initial suitability assessment: Applicant retook the assessment and passed within five (5) business days of the initial attempt, not to exceed three (3) attempt within thirty (30) days.	Not Applicable	One of the 12 new hires was exempt from taking the Berke Assessment due to being a licensed professional. All applicable staff passed the assessment on the first attempt.

Employees who have a break in service may be reemployed with the same agency without an additional suitability assessment if the break is less than eighteen (18) months. However, if the provider changed or updated the assessment tool used, there is evidence that the employee completed the new assessment.	Not Applicable	None of the new hires were previously employed by the program.
New Hire		
For New Hires-The background screening was completed and the applicant was determined eligible prior to the date of hire.	Compliance	Background screenings for all new hires were completed, and eligibility was confirmed prior to each hire date.
For employee, contractor, volunteer, or intern who provide services for ten (10) or more hours per month-The background screening was completed and volunteer/mentor or intern determined eligible prior services being provided.	Not Applicable	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.	Not Applicable	None of the background screenings completed for new hires during the review period required an exemption.
E-Verify		
The file contains proof of E-Verify for all new employees obtained from the Department of Homeland Security.	Compliance	All personnel files contained valid E-Verify confirmations from the Department of Homeland Security verifying employment eligibility.
5 Year Rescreening		
Five year re-screening was completed prior to the 5-year anniversary date of initial hire or prior to expiration of retained fingerprints date.	Not Applicable	None of the background screenings completed for new hires during the review period required an exemption.
Additional Comments: There are no additional comments for this indicator.		
1.1 - Annual Affidavit of Compliance with Good Moral Character Standards		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.1		Yes
		The agency has the required policy Section 100-1.1, Annual Affidavit of Compliance with Good Moral Character Standards, that was approved 12/24/2025 by the COO.
Affidavit of Annual Compliance with Level 2 Screening Standard (Form IG/BSU-006) is completed and submitted to BSU by January 31st.	Compliance	The Affidavit of Annual Compliance with Level 2 Screening Standard (Form IG/BSU-006) was completed and submitted to BSU by the required deadline of January 31.

Affidavit of Annual Compliance with Level 2 Screening Standard was submitted sent to BSU by (at minimum): a. fax confirmation b. email confirmation	Compliance	Each affidavit submission included documented proof of delivery to BSU, verified through fax or email confirmation.
Additional Comments: There are no additional comments for this indicator.		
1.2 - Provision of an Abuse Free Environment		Satisfactory with Exception(s)
Provider has a written policy and procedure that meets the requirement for Indicator 1.2		Yes The agency has the required policy Section 100-1.2, Provision of an Abuse-Free Environment, that was approved 12/24/2025 by the COO.
The program has a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation.	Compliance	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.	Compliance	The program has an established process for promptly reporting and documenting all child abuse hotline calls in accordance with state and agency policy. Staff are trained and compliant with reporting procedures.
The agency is an abuse free environment.	Exception	A total of fourteen surveys were completed for six youth and eight staff. Four of the staff surveys reported concerns with management, disappointment with the work environment and maintenance of the physical building, staff's lack of attention resulting in mistakes, and lack of youth engagement.
Additional Comments: There are no additional comments for this indicator.		
1.3 - Incident Reporting		Satisfactory with Exception(s)
Provider has a written policy and procedure that meets the requirement for Indicator 1.3		Yes The agency has the required policy Section 100-1.3, Incident Reporting, that was approved 12/24/2025 by the COO.
Data sources Reviewed	Dates Reviewed	Logbook Dates for Sample Size:
Incident reports Logbooks CCC reports Interview with Program Staff	July-December 2025	7/26/2025, 8/16/2025, 9/3/2025, 10/26/2025, 12/21/2025
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.	Exception	A total of 25 reportable incidents submitted to DJJ CCC were reviewed as reported on the DJJ CCC incident report log. The program was not able to locate the incident report documentation for two of the reported incidents. Three of the incidents were not reported to CCC within the required 2 hours (8/5/25, 8/11/25, and 8/16/25).

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The program completes follow-up communication tasks/special instructions as required by the CCC.	Compliance	The program completed all follow-up communication and special instructions from the CCC.
Incidents are documented in the program logs, and the CCC call is documented in the logbook for Shelter programs.	Exception	A random sample of five CCC reports were reviewed for documentation in the program logbook. Three of the five were not found to be documented as required. One noted CCC was called but was missing information about the incident being reported. The second incident was noted in the logbook but not the call to CCC. The third incident was not documented in the logbook nor was the call to CCC.
All incident reports are reviewed and signed by program supervisors/directors.	Compliance	All incident reports were reviewed and signed by program supervisors or directors.
Additional Comments: There are no additional comments for this indicator.		
1.4 - Training Requirements		Satisfactory with Exception(s)
Provider has a written policy and procedure that meets the requirement for Indicator 1.4	Yes	
	The agency has the required policy Section 100-1.4, Staff Training and Professional Development, that was approved 12/24/2025 by the COO.	
A total of 0 first-year non-licensed Mental Health Clinical Shelter staff file(s) were reviewed. 4 new hire staff and 4 annual staff files were reviewed for compliance with training completed within the required timeframe(s).		
Policy & New Hire Training		
Trainings that are required by the Network and other funders must be documented in each individual staff member's file and on the FLN Training Log or similar document with the minimum requirements i.e. Staff Name & Position, Date of Hire, Training anniversary used by agency (calendar, date of hire or fiscal), Training Name, Training Hours, Cumulative Total, Training Completion or Facilitation Date, Location of Training or Platform Used (when virtual).	Compliance	All required trainings mandated by the Network and other funders are properly documented in each staff member's file and recorded on the FLN Training Log, including all required details such as staff information, training dates, hours, and completion records.
Civil Rights & Federal Funds (United States Department of Justice) (Required within 30 DAYS of date of hire)	Compliance	All staff, including full-time, part-time, and on-call employees, completed Civil Rights & Federal Funds (U.S. Department of Justice) training within 30 days of hire, ensuring compliance with federal requirements.
Pre-Service Training		
Agency policies and procedures	Compliance	All new staff completed agency orientation and policy training prior to working independently.

Contraband Overview and Search Policy/Practice AND signed acknowledgment form by staff.	Compliance	Staff reviewed the Contraband Overview and Search Policy and signed the required acknowledgment form.
Behavior Management	Compliance	Behavior Management training was completed prior to independent work with youth.
Building/Facility layout	Compliance	Staff received orientation to the building and facility layout.
File Documentation/Paperwork Requirements	Compliance	File documentation and paperwork requirement training was completed as required.
Confidentiality (FYSB / DCF / Skill Pro)	Compliance	Confidentiality training (FYSB / DCF / SkillPro) was completed and documented in staff files.
CCC & Incident Reporting	Compliance	Staff completed CCC and Incident Reporting training prior to working independently.
Child Abuse Reporting	Compliance	Child Abuse Reporting training was completed and verified in the staff record.
Client Intake & Screening	Compliance	Client Intake and Screening training was completed prior to independent case assignment.
Client Orientation (Shelter only)	Compliance	Staff completed Client Orientation training on delivering new client orientations.
Fire Safety Equipment (In-person by a supervisor or other program trainer)	Compliance	Fire Safety Equipment training was completed in person by a supervisor or program trainer.
Fire Safety Equipment (Skill Pro #215 or DCF)	Compliance	Fire Safety Equipment (SkillPro #215 or DCF) training completion is documented.
Medical and Mental Health Alert System	Compliance	Medical and Mental Health Alert System training was completed as required.
Disaster Preparedness	Compliance	Disaster Preparedness training was completed and verified in training logs.
Universal Precautions / Communicable Diseases / Infection Control / Bloodborne Pathogens Part I & II	Compliance	Universal Precautions, Communicable Diseases, Infection Control, and Bloodborne Pathogens Parts I & II training were completed and documented.
CPR/First Aid (By CPR Certified Instructor)	Compliance	CPR/First Aid training was completed by a certified instructor prior to independent duty.
Video Camera Surveillance & Equipment	Not Applicable	The four employee files reviewed do not have access to video surveillance.
CINS/FINS Core	Compliance	CINS/FINS Core training was completed and verified.
Crisis Intervention [e.g., MAB (2-day/16 hours)]	Compliance	Crisis Intervention training (e.g., MAB or FN-approved equivalent) was completed and documented.
Florida Network Youth Suicide Prevention	Compliance	Florida Network Youth Suicide Prevention training was completed within the required timeframe.
Adolescent Development / Positive Youth Development	Compliance	Adolescent Development and Positive Youth Development training were completed and recorded.

Cultural Humility/Diversity	Compliance	Cultural Humility and Diversity training was completed through an approved provider (Bridge or RHYTTAC).
Mental Health and Substance Abuse	Compliance	Mental Health and Substance Abuse training was completed and documented in the staff record.
Skill Pro Required Trainings:		
Child Abuse: Recognition, Reporting and Prevention	Compliance	Staff completed Child Abuse: Recognition, Reporting, and Prevention training within the first 90 days of employment or service.
Equal Employment Opportunity	Compliance	Equal Employment Opportunity training was completed and documented within the first 90 days.
Human Trafficking Intervention for Direct Care Staff	Compliance	Human Trafficking Intervention for Direct Care Staff training was completed as required.
Information Security Awareness	Compliance	Information Security Awareness training was completed within the required timeframe.
Prison Rape Elimination Act (PREA) - Part 1	Compliance	Prison Rape Elimination Act (PREA) – Part 1 training was completed and documented in staff records.
Prison Rape Elimination Act (PREA) - Part 2	Compliance	Prison Rape Elimination Act (PREA) – Part 2 training was completed and verified in the staff file.
Sexual Harassment	Compliance	Sexual Harassment training was completed within the first 90 days of employment or service.
Trauma Responsive Practices	Compliance	Trauma Responsive Practices training was completed and documented as required.
Additional FL Network Required Trainings:		
Naloxone Training	Compliance	Naloxone training was completed and documented within the first 90 days of employment or service.
Adverse Childhood Experiences (ACEs) (Required for All Staff not completing NIRVANA)	Compliance	Adverse Childhood Experiences (ACEs) training was completed by all staff not participating in NIRVANA® training.
FL Statute 984 CINS Petition Training (Case Staffing & CINS Petition Staff Only)	Not Applicable	None of the four staff conduct case staffing duties.
STAFF SPECIFIC TRAINING - Florida Network and SkillPro Required Trainings Related to Specific Staff Roles		
JJIS (Juvenile Justice Information System) System Access (Required for staff who enter and monitor SVS prior to accessing JJIS)	Not Applicable	The four employee files reviewed do not have access to JJIS.
JJIS Alerts – Part 1 (JJIS Data Entry Staff prior to accessing JJIS)	Not Applicable	The four employee files reviewed do not have access to JJIS.
JJIS Alerts – Part 2 (JJIS Data Entry Staff prior to accessing JJIS)	Not Applicable	The four employee files reviewed do not have access to JJIS.

Motivational Interviewing (MI) (Prior to NIRVANA training for Staff who Administer the NIRVANA)	Compliance	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)	Compliance	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)	Compliance	Shelter staff without a medical license completed Medication Distribution training prior to administering medication and renewed annually.
PYXIS (Authorized Shelter Staff prior to accessing Pyxis system)	Compliance	Authorized shelter staff completed PYXIS training prior to accessing the Pyxis system.
SNAP Support Overview *This training does not certify staff to facilitate SNAP After completing training, this Supporter must only be paired with a fully trained SNAP Facilitator	Not Applicable	The four employee files reviewed do not need this training as they are not SNAP support.
SNAP Facilitator Training (Required for All Staff prior to the delivery of Groups)	Not Applicable	None of the four training records reviewed are for SNAP program staff.
NetMIS Training (For NetMIS Users prior to accessing NetMIS)	Compliance	NetMIS users completed NetMIS training prior to being granted system access.
NON-LICENSED CLINICAL STAFF ONLY Staff Suicide Assessment Training ** 20 hours including a minimum of five (5) one-to-one assessments of suicide risk in the physical presence of a licensed professional. This training is documented and maintained in the staff person’s personnel file using the Documentation of Non-Licensed Mental Health Clinical Staff Person’s Training in Assessment of Suicide Risk form. (Required for All shelter staff who are not licensed prior to independent assessment of suicide risk)	Not Applicable	The program has not hired a non-licensed clinical staff during the review period.
NON-LICENSED CLINICAL STAFF ONLY 16 hours clinical training + 36 hours topic-specific training (Covering: basic counseling skills, basic group therapy skills, treatment model and program philosophy, therapeutic milieu, behavior management, client rights, crisis intervention, early intervention and de-escalation, documentation requirements, normal and abnormal adolescent development, typical behavior problems) * Prior to working with youth*	Not Applicable	There were no eligible non-licensed shelter clinical staff hired during the review period.

<p>NON-LICENSED CLINICAL STAFF ONLY Mental health and substance-related disorders; Counseling theory and techniques; Group dynamics and therapy; Treatment and discharge planning. (Required for Bachelor’s level non-licensed counseling staff without 2 years clinical experience assessing, counseling or treating youth with serious emotional disturbance or substance abuse problems) *To be completed during first year of employment*</p>	<p>Not Applicable</p>	<p>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>Not Applicable</p>	<p>All mandatory trainings were completed within the required timeframes.</p>
<p>Direct Care staff (full-time, part-time, and on-call) complete all pre-service requirements prior to working independently and achieve a minimum of 80 hours of training during their first year.</p>	<p>Compliance</p>	<p>Direct-care staff completed all pre-service requirements prior to working independently and achieved at least 80 hours of training within their first year.</p>
<p>If there was a break in employment for less than six (6) months, the file contains documentation confirming the supervisor reviewed applicable prior training and verified completion.</p>	<p>Not Applicable</p>	<p>The four employee files reviewed had no break in employment.</p>
<p>If the agency finds that the instructor is not available for the instructor led course within the required timeframe, then document attempts in the staff training file.</p>	<p>Not Applicable</p>	<p>None of the four training records indicated instructor was not available to conduct trainings.</p>
<p>The agency has a designated staff member responsible to manage all employee’s individual training files and completes routine tracking and reviews of staff files to ensure compliance.</p>	<p>Compliance</p>	<p>The agency has a designated staff member responsible for managing all employee training files and routinely reviews them to ensure compliance.</p>
<p>All Network-required training is supported by documentation such as certificates, sign-in sheets, and agendas.</p>	<p>Compliance</p>	<p>All Network-required trainings are supported by appropriate documentation, including certificates, sign-in sheets, and training agendas.</p>
<p>Annual Training</p>		

Trainings that are required by the Network must be documented in each individual training file or employee file as well as captured on the FLN Training Log or similar document with the minimum requirements (i.e. Staff Name & Position, Date of Hire, Training anniversary used by agency (calendar, date of hire or fiscal), Training Name, Training Hours, Training Completion or Facilitation Date, Location of Training or Platform Used (when virtual), and Cumulative Total Training Hours)	Compliance	All Network-required trainings are documented in individual staff files and recorded on the FLN Training Log with all required details, including staff information, training hours, completion dates, and cumulative totals.
Child Abuse: Recognition, Reporting, and Prevention (Annually)	Compliance	Child Abuse: Recognition, Reporting, and Prevention training is completed annually and properly documented in staff training records.
Human Trafficking Intervention for Direct-Care Staff (Annually)	Compliance	Human Trafficking Intervention for Direct-Care Staff training is completed annually and supported by required documentation.
Information Security Awareness (Annually)	Compliance	Information Security Awareness training is completed annually and verified through certificates or attendance records.
Prison Rape Elimination Act (PREA) Part 1 (Every 2 years)	Compliance	Prison Rape Elimination Act (PREA) Part 1 training is completed every two years and properly documented in training files.
Prison Rape Elimination Act (PREA) Part 2 (Every 2 years)	Compliance	Prison Rape Elimination Act (PREA) Part 2 training is completed every two years and supported by appropriate documentation.
Sexual Harassment (Every 2 Years)	Compliance	Sexual Harassment training is completed every two years and verified in staff files.
Trauma Responsive Practices (Every 2 Years)	Compliance	Trauma Responsive Practices training is completed every two years and documented on the FLN Training Log and in staff training files.
FL Network Annual Required Trainings REQUIRED for Staff Over 1 year		
Florida Network Youth Suicide Prevention (Required Annually)	Compliance	Florida Network Youth Suicide Prevention training is completed annually and documented in staff training files.
CPR (Every 2 Years - Check for current validity)	Exception	Out of the four employee training files reviewed, one was missing the CPR required two year certification.
First Aid (Every 2 Years - Check for current validity)	Exception	Out of the four employee training files reviewed, one was missing the First Aid required two year certification.
Crisis Intervention training approved by the Network (ex: Managing Aggressive Behavior (MAB) (Every 2 Years)	Compliance	Crisis Intervention training (e.g., Managing Aggressive Behavior – MAB) is completed every two years as approved by the Network.
In-Person Fire Safety Equipment (Every 2 years)	Compliance	In-person Fire Safety Equipment training is completed every two years and properly documented.
Virtual Fire Safety Equipment (Every 2 years)	Compliance	Virtual Fire Safety Equipment training is completed every two years and properly documented.

Medication Distribution for Staff Without a Medical License (Re-certification annually)	Compliance	Medication Distribution training for staff without a medical license is re-certified annually and verified through documentation.
SNAP Refresher Training (Annually for all staff who have completed SNAP Facilitator Training and are delivering SNAP group services or monitoring fidelity)	Compliance	SNAP® Refresher Training is completed annually for all staff delivering SNAP® group services or conducting fidelity monitoring.
For missed trainings, documentation includes the reason for delay and scheduled completion timeline.	Compliance	One community counseling staff file reviewed missed the CPR/First Aid training. Communication has been sent via email, as well as through text messages reminding the employee to complete the training. The request was done prior to the expiration date of 12/21/25. On 1/8/2026, staff received an email that the employee will complete the CPR/First Aid course on 2/14/2026.
All direct care Community Counseling staff meet the annual requirement of a minimum of 24 hours of total hours of training hours received for the year.	Not Applicable	None of the four employee files reviewed are Community Counseling staff.
All direct care Shelter Staff meet the annual requirement of a minimum of 40 hours for residential programs licensed by DCF of the total hours of training received for the year. *This includes residential counselor or other direct care staff positions working with youth in shelter.*	Compliance	All direct-care Shelter staff meet the annual minimum requirement of 40 total training hours, as required for residential programs licensed by DCF.
Annual and Biannual training must be due on a calendar or fiscal year basis, not based on hire date.	Compliance	Annual and biannual training schedules are tracked and completed based on the agency's established calendar or fiscal year cycle, not hire date.
All Network-required training is supported by documentation such as certificates, sign-in sheets, and agendas.	Compliance	All Network-required trainings are supported by documentation such as certificates, sign-in sheets, and training agendas.
Additional Comments: There are no additional comments for this indicator.		
1.5 - Data Entry & Collection		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.5		Yes
		The agency has the required policy Section 100-1.5, Data Entry and Documentation Standards, that was approved 12/24/2025 by the COO. The agency also has a Performance and Quality Improvement Plan (PQI) that was approved October 2024.
The program has a quality improvement process in place to review and improve accuracy of data entry and collection.	Compliance	The program maintains an active quality improvement process to review and enhance the accuracy of data entry and collection.

Client and service data is entered electronically into the Florida Network Management Information System (NetMIS) within three (3) business days of service commencement (as reported on most recent End-of-Month ('EOM') report).	Compliance	Client and service data are entered electronically into the Florida Network Management Information System (NetMIS) within three (3) business days of service commencement, as verified in the most recent End-of-Month (EOM) report.
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.	Compliance	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
Additional Comments: There are no additional comments for this indicator.		
1.6 - Risk Management/ Analyzing and Reporting Information		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.6		Yes
		The agency has the required policy Section 100-1.5, Risk Management and Safety, that was approved 12/24/2025 by the COO. The agency also has a Performance and Quality Improvement Plan (PQI) that was approved October 2024.
Data sources Reviewed		Dates Reviewed
Peer Record reviews; Quarterly PQI meetings held July and October 2025; Program Data analysis 2024 and 2025; Staff Meetngs; and Board meetings held 10/15 and 7/18/2025.		July - December 2025.
The program provides reports of aggregated data and committee/workgroup minutes analyzing information.	Compliance	The program consistently compiles and maintains aggregated data reports and meeting minutes from committees and workgroups, demonstrating active analysis and ongoing program improvement.
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.)	Compliance	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.	Compliance	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.	Compliance	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.	Compliance	Program outcome data is reviewed annually to assess performance against goals and inform quality improvement efforts.

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There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	Compliance	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.	Compliance	Program performance is routinely presented to the Board of Directors. All final reports receiving a Limited or Failed rating are submitted to the Executive Committee electronically or by mail, as required.
Evidence shows that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	Compliance	Documentation reflects that program strengths and weaknesses are identified, corrective actions implemented, and staff are informed and engaged throughout the improvement process.
Additional Comments: There are no additional comments for this indicator.		
1.7 - Client Transportation		Limited
Provider has a written policy and procedure that meets the requirement for Indicator 1.7	Yes	
	The agency has the required policy Section 100-1.7, Transportation of Youth, that was approved 12/24/2025 by the COO.	
Supervisors complete a weekly review of transport documentation and provide written feedback or coaching when deficiencies are found.	Exception	The program's policy requires weekly reviews of the transportation documentation; however, there were no transport documentation reviews located for the review period.
The agency has a practice, review, and approval process in place regarding the transportation of youth assigned to the program.	Compliance	The agency maintains an established transportation policy and formal approval process that governs all youth transports, ensuring safety and accountability.
All drivers have an approved driver's license.	Compliance	All approved drivers hold valid driver's licenses verified by the agency prior to transporting youth.
List of approved drivers eligible to drive client(s) for the agency or approved private vehicle that considers the driver's work performance and history, indicating no inappropriate behavior is likely to occur.	Compliance	The agency maintains a current list of approved drivers eligible to transport clients, confirming each driver's satisfactory work performance and history free from inappropriate behavior.
The list of approved drivers are covered under the agency's automobile insurance.	Compliance	All approved drivers are covered under the agency's automobile insurance policy, and verification of coverage is maintained on file.

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<p>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.</p>	<p>Compliance</p>	<p>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.</p>
<p>Signed parental consent is obtained in advance of any single transport.</p>	<p>Exception</p>	<p>Five of ten single transport incidents reviewed did not have parental consent documentation; one was a dependent youth without the consent form.</p>
<p>If a single staff is transporting youth in a vehicle, there is evidence that the Program Director approved it (prior to the transport) and the approval is documented accordingly prior to the client transport.</p>	<p>Exception</p>	<p>Four of ten single transport incidents reviewed were not documented in the logbook, and the transport van log did not contain the information of approval or youth name.</p>
<p>If there is no signed parental consent for single staff transport and the transport is necessary and cannot be delayed; in addition to the single staff transportation requirements above, there is evidence that the transporting employee completed a check-in by phone at agreed-upon intervals with the senior program leader or designee, upon departure and arrival. The employee check-ins must be documented by the manager or designee receiving the call.</p>	<p>Exception</p>	<p>Four of ten single transport incidents reviewed were not documented in the logbook, hence, check-in documentation was missing.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>1.8 - Client Contact Policy</p>		<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 1.8</p>		<p>Yes The agency has the required policy Section 100-1.8, Client Contact and Conflict of Interest, that was approved 12/24/2025 by the COO.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>1.9 - Community Referrals and Outreach Services</p>		<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 1.9</p>		<p>Yes The agency has the required policy Section 100-1.9, Community Referrals and Outreach, that was approved 12/24/2025 by the COO.</p>

<p>Outreach activities include education about services offered and guidance on accessing those services.</p> <p>The following mandatory information of each outreach activity is entered into NETMIS: the title, date, duration (hours), zip code, location, description, estimated number of people reached, modality, target audience and topic.</p> <p>The activities include group presentations/discussions, individual meetings, short-term intervention groups, set up/display and distribution of materials at community events, conducting tours of facilities, and media events or interviews.</p>	<p>Compliance</p>	<p>The program’s outreach activities effectively educate the community about available services and provide clear guidance on how to access them. All required details, including title, date, duration, location, description, estimated attendance, modality, target audience, and topic, are accurately entered into NETMIS.</p>
<p>The program has evidence that provides minutes of the event or other verification of staff participation.</p>	<p>Compliance</p>	<p>Documentation such as meeting minutes, sign-in sheets, and event summaries confirm active staff participation in all outreach activities.</p>
<p>The program has a lead staff member who conducts outreach, is designated to participate in local DJJ Board and council meetings and leads other outreach activities.</p>	<p>Compliance</p>	<p>A designated staff member serves as the program’s outreach lead, participates in local DJJ Board and council meetings, and coordinates all outreach efforts on behalf of the program.</p>
<p>This responsibility is specified in their job description.</p>	<p>Compliance</p>	<p>The outreach lead’s job description clearly defines responsibility for community engagement, DJJ participation, and oversight of outreach activities.</p>
<p>Full-Service agencies document meetings with local stakeholders (school districts, judges, and law enforcement) at least two times per year to discuss services available and needed improvements.</p>	<p>Compliance</p>	<p>Full-service agencies maintain ongoing collaboration with key stakeholders, including school districts, judges, and law enforcement, and meet at least twice per year to review services and discuss opportunities for improvement.</p>
<p>Outreach activities include education about services offered and guidance on accessing those services. The program has evidence that provides minutes of the event or other verification of staff participation.</p>	<p>Compliance</p>	<p>Outreach efforts include a variety of engagement methods such as group presentations, individual meetings, short-term intervention groups, informational displays at community events, facility tours, and media participation. These activities demonstrate strong community visibility and connection.</p>
<p>The program maintains written agreements with other community partners, which include services provided and a comprehensive referral process.</p>	<p>Compliance</p>	<p>The program maintains current written agreements with community partners outlining provided services and a clearly defined referral process that supports coordinated care.</p>
<p>Copies of agreements are forwarded to the Florida Network.</p>	<p>Compliance</p>	<p>Copies of all partnership agreements are submitted to the Florida Network as required, ensuring transparency and statewide coordination of services.</p>

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Additional Comments: There are no additional comments for this indicator.		
Domain Three		
3.2 - Admission Process	Limited	
Provider has a written policy and procedure that meets the requirement for Indicator 3.2	Yes	
	The agency has the required policy Section 300-3.2, Admission Process, that was approved 12/24/2025 by the COO.	
A total of ten file(s) were reviewed during this evaluation period. Of these, four were open and six were closed. Among the open file(s), two residential (RES) and two community counseling file(s) were reviewed. Among the closed file(s), four residential (RES) and two community counseling file(s) were reviewed.		
The screening form is completed immediately for all inquiries into shelter placement.	Compliance	For all inquiries into shelter placement, screening forms were completed immediately by trained staff, ensuring timely assessment and appropriate service placement.
<u>For Community Counseling Services:</u> The initial screening for eligibility for Community Counseling Services (including screening for eligibility, crisis counseling and information, and referral) occurs within 3 business days of referral by a trained staff member using, at minimum, the Florida Network screening form.	Compliance	Initial screenings for Community Counseling Services were completed within three business days of referral by trained staff using the Florida Network screening form. All eligibility, crisis, and referral requirements were met.
Youth and parents/guardians receive the following in writing		
Youth and parents/guardians are provided available service options in writing.	Compliance	Youth and parents/guardians were provided written information outlining all available service options, ensuring informed decision-making about participation.
Youth and parents/guardians are provided "Rights and Responsibilities of Youth" in writing.	Compliance	Written materials detailing the rights and responsibilities of youth were provided at intake, and documentation confirmed receipt in all reviewed files.
Parents/guardians are provided "Rights and Responsibilities of Parents" and/or parent brochure.	Compliance	Parents and guardians were provided the "Rights and Responsibilities of Parents" brochure at intake, and signed acknowledgment forms were present in all records.
The following is also available to the youth and parents/guardians:		
Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication).	Exception	Documentation of information provided to residential clients about possible actions through involvement in CINS/FINS was not found for all six residential client files reviewed.

Youth and parents/guardians are provided information regarding the programs grievance procedures.	Compliance	All youth and parents/guardians were informed of the program’s grievance procedures, and documentation confirmed this information was reviewed and acknowledged.
If the youth and family do NOT participate in services, the reason is documented on the screening form and logged in NetMIS.	Not Applicable	All youth and family participated in services.
The intake took place in a setting that allows the client to feel safe and heard.	Compliance	Intakes were conducted in private, trauma-informed settings designed to help youth feel safe, respected, and heard throughout the process.
Additional Comments: There are no additional comments for this indicator.		
3.3 - NIRVANA (Network Inventory of Risks, Victories, and Needs Assessment)		Satisfactory with Exception(s)
Provider has a written policy and procedure that meets the requirement for Indicator 3.3		Yes
		The agency has the required policy Section 300-3.3, NIRVANA (Network Inventory of Risks, Victories and Needs Assessment) that was approved 12/24/2025 by the COO.
For youth in shelter care: NIRVANA Assessment initiated within 72 hours of admission.	Compliance	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.	Compliance	All NIRVANA Assessments for shelter youth were completed within seven days of intake, confirming timely completion of assessment requirements.
NIRVANA Assessment is completed within one to two contacts following the initial intake date into services.	Compliance	All Community Counseling NIRVANA Assessments were completed within one to two contacts after intake, consistent with Florida Network guidelines.
NIRVANA Assessment is initiated at intake.	Compliance	All assessments were completed by qualified bachelor’s or master’s level staff who successfully completed both NIRVANA and Motivational Interviewing
NIRVANA Assessment was conducted by a bachelor’s or master’s degree staff who has completed the Florida Network NIRVANA training and has had Motivational Interviewing (MI).	Compliance	All assessments were completed by qualified bachelor’s or master’s level staff who successfully completed both NIRVANA and Motivational Interviewing training, verified through the staff roster.
All completed NIRVANA assessments are entered electronically into the Florida Network Management Information System (NetMIS) within three (3) business days of service commencement.	Compliance	All completed NIRVANA Assessments were entered into NetMIS within three business days of service commencement, ensuring timely data submission and compliance with reporting standards.

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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.	Exception	One out of ten cases reviewed had a supervisor signature which was over seven business days.
(Shelter only) NIRVANA Self-Assessment Report (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	Compliance	For all shelter admissions, the NIRVANA Self-Assessment Report (NSR) was completed within 24 hours, with any exceptions fully documented in NetMIS and the youth's file.
A NIRVANA Post-Assessment is completed at discharge for youth who have a length of stay that is greater than 30 days.	Exception	Four of ten client files reviewed are for open cases. One closed case which was open for more than 30 days lacked a NIRVANA post assessment.
A NIRVANA Re-Assessment is completed every 90 days with the exception of SNAP services.	Exception	Eight of ten cases reviewed were not open for 90 days. Documentation for one case reviewed lacked a 90 day NIRVANA reassessment.
All files must have the interview guide and/or printed NIRVANA.	Compliance	Each file reviewed contained a completed interview guide and/or a printed copy of the NIRVANA Assessment, demonstrating proper documentation and retention.
Additional Comments: There are no additional comments for this indicator.		
3.4 - Case Management, Counseling & Non-Residential Services Policy		Satisfactory with Exception(s)
Provider has a written policy and procedure that meets the requirement for Indicator 3.4		Yes
		The agency has the required policy Section 300-3.7 Service Plans, that was approved 12/18/2025 by the COO.
Each client is assigned a Counselor.	Compliance	Each client was assigned a qualified counselor responsible for coordinating services and maintaining consistent therapeutic engagement.
The following is also available to the youth and parents/guardians:		
In the Shelter Program: 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.	Compliance	In the Shelter Program, individual and/or family counseling sessions were provided at least once per week by a licensed mental health provider or by unlicensed staff under the supervision of a licensed clinician.

<p>Community Counseling Program: Counseling 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)</p>	<p>Exception</p>	<p>Documentation of services completed or offered for a two week period was missing for one community counseling youth.</p>
<p>The reason(s) why a required weekly session could not be provided is documented in the youth’s file and in NetMIS.</p>	<p>Exception</p>	<p>Chronological notes in the file and notes in NetMIS show a gap in services from 11/19/2025 to 12/2/2025. Notes for 12/3/2025 is also missing from client file chronological notes. The reason for missed services from 11/20/2025 to 12/3/2025 is not documented.</p>
<p>If case management needs extend beyond the counselor's role, a case manager is assigned.</p>	<p>Compliance</p>	<p>When case management needs exceeded the counselor’s role, a dedicated case manager was promptly assigned to ensure comprehensive service coordination.</p>
<p>Case Manager establishes appropriate referrals to services.</p>	<p>Compliance</p>	<p>Case managers established appropriate community referrals and coordinated follow-up services to address the youth’s individual needs.</p>
<p>All counseling and case management sessions are documented in the youth’s file and NetMIS, including the reason for missed sessions.</p>	<p>Exception</p>	<p>One case of the ten reviewed lacked documentation for weekly services completed or offered.</p>
<p>If mental health or substance abuse needs, outside of the program’s capacity, are identified appropriate referrals are made and documented.</p>	<p>Compliance</p>	<p>When mental health or substance abuse issues outside program capacity were identified, appropriate referrals were made to external providers and fully documented.</p>
<p>For youth receiving Respite Services (DV, Probation & PDC): A minimum of one family counseling session is offered to address reunification planning and related concerns. If the session is not conducted, the reason is documented in the youth’s case file, including any barriers to participation or service delivery.</p>	<p>Compliance</p>	<p>For youth in Respite Services (DV, Probation, or PDC), at least one family counseling session was offered to support reunification planning. When sessions did not occur, reasons and barriers were clearly documented in the youth’s file.</p>
<p>Clients that do not receive services for 30 days or more have their case closed.</p>	<p>Not Applicable</p>	<p>None of the youth surpassed 30 days without services.</p>

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<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>Compliance</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>Additional Comments: There are no additional comments for this indicator.</p>		
<p>3.5 - Adjudication Services: Case Staffing</p>		<p>Satisfactory with Exception(s)</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 3.5</p>	<p>Yes The agency has the required policy Section 300-3.5 Adjudication Services: Case Staffing, that was approved 12/18/2025 by the COO.</p>	
<p>A total of two applicable community counseling files were reviewed during this evaluation period. Of these, one was open and one was closed.</p>		
<p>A case staffing committee meeting is scheduled when one of the following occur (at minimum): 1. the youth/family is not in agreement with services or treatment; 2. the youth/family will not participate in the services selected, 3. the youth’s referring problem has not shown substantial improvement within six weeks of initiating counseling. 4. the program receives a written request from the parent/guardian or any other member of the committee</p>	<p>Compliance</p>	<p>Case staffing committee meetings are scheduled as required when the youth or family is not in agreement with services, will not participate, demonstrates limited progress within six weeks, or upon written request from the parent/guardian or committee member.</p>
<p>Each case staffing must be recorded in NetMIS within the case, noting the date it occurred.</p>	<p>Compliance</p>	<p>Each case staffing is accurately recorded in NetMIS within the case record, including the date of occurrence.</p>
<p>The case staffing is convened within 7 days (excluding weekends and legal holidays) of the parent/guardian request.</p>	<p>Exception</p>	<p>The case staffing meeting was not scheduled within 7 days of the request for two records reviewed.</p>
<p>Notification to the family is sent no less than 5 working days prior to staffing.</p>	<p>Compliance</p>	<p>Families receive written notification of the staffing meeting at least five (5) working days prior to the scheduled date.</p>
<p>Notification to the committee is sent no less than 5 working days prior to the staffing date.</p>	<p>Compliance</p>	<p>Committee members receive notification of the staffing meeting at least five (5) working days in advance.</p>

A written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations.	Exception	Written report for case staffed during the QI review was not yet available. The second case staffed did not include a report for the case staffing.
As a result of the case staffing committee meeting, the youth and family are provided a new or revised plan for services.	Compliance	Following the case staffing committee meeting, the youth and family receive a new or revised service plan reflecting the committee’s recommendations.
At a minimum, the case staffing is attended by:		
Local school district representative	Compliance	Each case staffing includes attendance by a local school district representative as required.
DJJ rep. or CINS/FINS provider	Compliance	A DJJ representative or CINS/FINS provider participates in each case staffing meeting in accordance with established guidelines.
Other members may include:		
State Attorney’s Office	Compliance	A representative from the State Attorney’s Office participates in case staffing meetings as appropriate.
Mental health representative	Compliance	A mental health representative participates in case staffing meetings when applicable.
Substance abuse representative	Compliance	A substance abuse representative participates in case staffing meetings as needed.
Law enforcement representative	Compliance	A law enforcement representative participates in case staffing meetings when appropriate.
DCF representative	Compliance	A DCF representative participates in case staffing meetings as applicable.
Others requested by youth/family	Not Applicable	There were no additional representatives requested by the families.
The program has an established case staffing committee, and has regular communication with committee members.	Compliance	The program maintains an established case staffing committee with active and consistent communication among all members.
The program has an established case staffing committee, and has regular communication with committee members.	Compliance	Regular collaboration and communication with case staffing committee members are maintained to ensure coordinated planning and support for youth and families.
Additional Comments: There are no additional comments for this indicator.		
3.6 - Adjudication Services: CINS Petition Process		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.6		Yes
		The agency has the required policy Section 300 - 3.6 Adjudication Services- CINS Petition Process, that was approved 12/18/2025 by the COO.

If applicable, the program works with the circuit court for judicial intervention for the youth/family, as applicable, including required attendance at all court hearings without subpoena.	Not Applicable	The program has not filed a CINS Petition during the review period.
The Case Manager/Counselor completes a review summary prior to the court hearing.	Not Applicable	The program has not filed a CINS Petition during the review period.
Additional Comments: There are no additional comments for this indicator.		
3.7 - Service Plan		Satisfactory with Exception(s)
Provider has a written policy and procedure that meets the requirement for Indicator 3.7		Yes
		The agency has the required policy Section 300-3.7 Service Plans, that was approved 12/18/2025 by the COO.
A Case/Service Plan is developed within seven (7) working days of the youth's intake in the shelter program.	Compliance	The Case/Service Plan is completed within seven working days of intake, ensuring timely service initiation.
A Case/Service Plan is developed within one contact following the completion of the NIRVANA in the community counseling program.	Compliance	The Case/Service Plan is completed within one contact of the NIRVANA, demonstrating prompt follow-up and coordination.
The plan is developed on a local provider approved form or through NETMIS based on information gathered during initial screening, intake, and NIRVANA.	Compliance	The Case/Service Plan is completed using approved provider forms or NETMIS, based on information from screening, intake, and NIRVANA.
Youth and parents/guardians receive the following in writing		
The Case/Service Plan reflects the individualized and prioritized needs and goals identified during the assessment process, including relevant domains from the NIRVANA.	Compliance	Individualized and prioritized needs and goals are clearly identified based on the assessment process, incorporating all relevant domains from the NIRVANA.
Each plan clearly documents the type of service(s) to be provided, the frequency, and the location of services.	Compliance	Each plan clearly outlines the type, frequency, and location of services to ensure structured and consistent service delivery.
The plan identifies the person(s) responsible for implementing each service or action step.	Compliance	The plan specifies the person(s) responsible for implementing each service or action step, promoting accountability and effective follow-through.
The target date(s) for completion are documented in the service plan.	Exception	No target date appeared on one of ten case file service plans.
The actual completion date(s) are documented in the service plan.	Exception	The case service plan for four of the six closed cases did not document actual completion date(s) for any of the goals listed.
The signature of the youth is documented in the service plan.	Exception	Youth refused to sign case plan in one of the files provided for review.

The signature of the parent/guardian is documented in the service plan.	Exception	Parent signatures were not in three case files but two parents were not physically present when the plan was developed and were informed verbally.
If unavailable, the absence is documented with a reason on the plan.	Exception	One case file did not include a note for missing parent signature.
The signature of the counselor is documented in the service plan.	Compliance	Counselor signatures are included on all plans, verifying professional oversight and approval of service goals and actions.
The signature of the LMHP reviewing the plan is signed within seven (7) days of plan completion.	Compliance	The plan includes the LMHP’s signature within seven days of completion, confirming timely clinical review and oversight.
The date of plan initiation is clearly indicated.	Compliance	The date of plan initiation is clearly documented, ensuring clarity on when services and interventions began.
The Case/Service Plan is formally reviewed and revised in collaboration with the youth and parent(s)/guardian(s):		
At, 30 Days, following plan initiation.	Exception	Three case files were overdue when the 30 day service plan review was completed.
At, 60 Days, following plan initiation.	Exception	One file for case open more than 60 days did not include 60 day review.
At, 90 Days, following plan initiation.	Exception	One file for case open more than 90 days did not include 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.	Not Applicable	There were no eligible court-ordered youth during the review period.
Additional Comments: There are no additional comments for this indicator.		
3.8 - Youth Records		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.8		Yes
		The agency has the required policy Section 300-3.8 Youth Records, that was approved 12/18/2025 by the COO.
All records are marked “confidential”.	Compliance	All youth records were clearly marked “Confidential,” ensuring proper identification and adherence to privacy requirements.
All records are kept in a secure room or locked in a file cabinet that is marked “confidential” and only accessible by staff.	Compliance	All records were stored securely in locked file cabinets or designated confidential rooms accessible only to authorized staff.
When in transport, all records are locked in an opaque container marked “confidential”.	Compliance	When transported, all records were placed in locked, opaque containers marked “Confidential,” maintaining privacy and data security.

<p>All records are maintained in a neat and orderly manner.</p>	<p>Compliance</p>	<p>Records were consistently maintained in a neat, orderly, and professional manner, ensuring quick access and review readiness.</p>
<p>SHELTER FILES</p> <ol style="list-style-type: none"> 1. Table of Contents that outlines documents in each section 2. Screening 3. Informed Consent 4. Photograph of the youth 5. Shelter Intake Form 6. Suicide Assessment (if needed) 7. NIRVANA Self Report (NSR) 8. NIRVANA full Assessment 9. Plan of Service 10. Chronological Notes 11. Medication Inventory Form 12. Approved contact list 13. Copies of referrals made (if needed) 14. Discharge summary once case is closed 	<p>Compliance</p>	<p>Each Shelter file contained all required documents, including a table of contents, screening forms, consent forms, youth photograph, intake documentation, NIRVANA assessments, Plan of Service, chronological notes, medication inventory, approved contact list, referral documentation, and discharge summary.</p>
<p>COMMUNITY COUNSELING FILES</p> <ol style="list-style-type: none"> 1. Table of Contents that outlines documents in each section 2. Screening 3. Informed Consent 4. Community Counseling Intake Form 5. Suicide Assessment (if needed) 6. NIRVANA full Assessment 7. Plan of Service 8. Chronological case notes 9. Copies of referrals made (if needed) 10. Discharge summary once the case is closed 	<p>Compliance</p>	<p>Each Community Counseling file included all required documents, including a table of contents, screening forms, informed consent, intake documentation, NIRVANA assessment, Plan of Service, chronological notes, referrals, and discharge summary.</p>
<p>If records are kept electronically, the records are maintained securely and can be made immediately available upon request for audit purposes.</p>	<p>Compliance</p>	<p>Electronic records were securely maintained within password-protected systems with access limited to authorized personnel and were readily available upon request for audit purposes.</p>

Records are retained for five years after the termination date of the contract that is funding the youth’s service.	Compliance	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.
Additional Comments: There are no additional comments for this indicator.		
3.10 - Discharge and Follow Up		Satisfactory with Exception(s)
Provider has a written policy and procedure that meets the requirement for Indicator 3.10		Yes
		The agency has the required policy Section 300-3.10 Discharge and Follow-Up, that was approved 12/01/2025 by the COO.
30 day follow-ups are provided post discharge for all youth served.	Compliance	Follow-up contacts were completed within 30 days post-discharge, with documentation confirming continued client stability and connection to recommended services.
60 day follow-ups are provided post discharge for all youth served.	Compliance	Follow-up contacts were also completed within 60 days post-discharge, ensuring ongoing support and successful transition for youth and families.
Each file contains a discharge summary that describes the reason for termination.	Compliance	Discharge summaries clearly described the reason for termination, confirming appropriate closure of services and alignment with client progress.
Each file contains a discharge summary that outlines the events of the case, services provided, and progress of the youth and family.	Compliance	Each discharge summary outlined key case events, services provided, and measurable progress made by the youth and family throughout service delivery.
Each file contains a discharge summary that describes the living arrangements of the child at termination. If the child is not returned to the family at termination, the discharge summary must contain the reasons for the alternative placement, plans for the child’s living arrangement, and interim objectives set that will accomplish an eventual return, if possible and when appropriate.	Compliance	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.
Each file contains a discharge summary that outlines the aftercare recommendations and the arrangements for case follow-up.	Compliance	Discharge summaries detailed aftercare recommendations and follow-up arrangements, ensuring continuity of care and resource connection beyond program exit.
Each file contains a NIRVANA Post Assessment.	Exception	One closed file did not contain a NIRVANA post assessment.

<p>For cases that are referred for services by Truancy Court for FINS services, or to the case staffing committee for consideration of a CINS petition as a result of truancy related issues; youth having been deemed Truant by the Court, the Provider shall verify school attendance during 30- and 60-day follow-ups if the youth remains subject to compulsory education. If verification cannot be obtained, efforts are documented in the youth's file.</p>	<p>Not Applicable</p>	<p>None of the 10 records reviewed were referred by the Truancy Court.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>Domain Four</p>		
<p>4.0 - SNAP® Under 12</p>	<p>Satisfactory</p>	
<p>Provider has a written policy and procedure that meets the requirement for Indicator 4.0</p>	<p>Yes</p>	
	<p>The agency has the required policy Section 400-4.0, SNAP under 12, that was approved 12/1/2025 by the COO.</p>	
<p>A total of five SNAP® Under 12 file(s) were reviewed during this evaluation period. Of these, two were open and three were closed.</p>		
<p>Youth are screened to determine eligibility of services using the Florida Network Youth Screening Form.</p>	<p>Compliance</p>	<p>Youth are screened for service eligibility using the Florida Network Youth Screening Form prior to initiation.</p>
<p>The following documentation is required BEFORE initiating SNAP® services and located within the Youth File:</p>		
<p>SNAP® Client File Checklist</p>	<p>Compliance</p>	<p>The SNAP® Client File Checklist is completed and on file before services begin.</p>
<p>Florida Network CINS/FINS Youth Screening Form</p>	<p>Compliance</p>	<p>The Florida Network CINS/FINS Youth Screening Form is present and completed prior to service initiation.</p>
<p>SNAP® Brief Intake Screening Checklist (BISC)</p>	<p>Compliance</p>	<p>The SNAP® Brief Intake Screening Checklist (BISC) is completed and filed before service initiation.</p>
<p>The file contains the Florida Network Community Counseling Intake Form</p>	<p>Compliance</p>	<p>The Florida Network Community Counseling Intake Form is included in the youth file prior to services.</p>
<p>The NIRVANA Assessment</p>	<p>Compliance</p>	<p>The NIRVANA® Assessment is completed and filed before services begin.</p>
<p>The Reinforcement Trap Cycle</p>	<p>Compliance</p>	<p>The Reinforcement Trap Cycle is completed and included in the youth file prior to services.</p>
<p>The SNAP® Parenting Goal Sheet</p>	<p>Compliance</p>	<p>The SNAP® Parenting Goal Sheet is completed and on file prior to services.</p>
<p>The Child Way To Go Goal Sheet</p>	<p>Compliance</p>	<p>The Child Way To Go Goal Sheet is completed and on file prior to services.</p>
<p>The SNAP Child Screening Interview</p>	<p>Compliance</p>	<p>The SNAP® Child Screening Interview is completed and documented before services begin.</p>
<p>Consent to Treatment and Participation in Research Form</p>	<p>Compliance</p>	<p>Consent to Treatment and Participation in Research is signed and on file prior to service initiation.</p>

Tool of Parenting Self-Efficacy (TOPSE) – pre-assessment	Compliance	The Tool of Parenting Self-Efficacy (TOPSE) pre-assessment is completed and filed prior to services.
Child Behavior Checklist (CBCL) – caregiver	Compliance	The Child Behavior Checklist (CBCL) caregiver form is completed and filed prior to services.
Session Preparation and Delivery Activities		
Staff conduct weekly check-in calls with youth and caregivers.	Compliance	Staff complete and document weekly check-in calls with youth and caregivers as scheduled.
Weekly attendance is documented for youth.	Compliance	Weekly youth attendance is documented on the Youth Attendance Chart.
Weekly attendance is documented for caregiver.	Compliance	Weekly caregiver attendance is documented on the Caregiver Attendance Chart.
Weekly attendance is documented for siblings.	Not Applicable	None of the five files reviewed had siblings in attendance.
If needed, make-up sessions and the Adherence Contact Notes are completed.	Compliance	Make-up sessions and Adherence Contact Notes are completed and documented when needed.
Each GROUP CYCLE MUST include the following documentation:		
SNAP® Pre-brief Checklist	Compliance	The SNAP® Pre-brief Checklist is completed for each group cycle.
Weekly Feedback Questionnaires	Compliance	Weekly Feedback Questionnaires are completed and filed for each session.
Weekly Youth Evaluation Forms	Compliance	Weekly Youth Evaluation Forms are completed and filed.
Weekly Caregiver Evaluation Forms	Compliance	Weekly Caregiver Evaluation Forms are completed and filed.
SNAP® Debrief Checklist completed after each session and uploaded within three (3) business days	Compliance	The SNAP® Debrief Checklist is completed after each session and uploaded within three (3) business days.
Discharge and Post-Assessment Documents & Required Discharge Documentation includes:		
SNAP® Group Evaluation Forms (Week 13 – youth and caregiver)	Compliance	Week 13 SNAP® Group Evaluation Forms (youth and caregiver) are completed and filed.
Post-TOPSE entered into NetMIS (in file from NetMIS)	Compliance	Post-TOPSE results are entered into NetMIS and filed from NetMIS.
Post Child Behavior Checklist (CBCL) – (entered into ASEBA-Web in Youth File)	Compliance	Post-CBCL results are entered into ASEBA-Web and filed in the youth record.
Post-NIRVANA entered into NetMIS (youth file from NetMIS)	Compliance	Post-NIRVANA results are entered into NetMIS and filed from NetMIS.
Discharge and Post-Assessment Documents & Required Discharge Documentation includes:		
Discharges are completed within 30 days of group completion	Compliance	Discharges are completed within thirty (30) days of group completion.
If a post-assessment is not completed, there are at least three (3) DOCUMENTED attempts to collect each post-assessment.	Compliance	When post-assessments are not completed, at least three (3) documented attempts are recorded for each measure.
SNAP® Discharge Report is filed	Compliance	The SNAP® Discharge Report is completed and filed.
SNAP Discharge Report includes: Reason for discharge	Compliance	The discharge report includes the reason for discharge.

Summary of services delivered and goal progress	Compliance	The discharge report summarizes services delivered and progress toward goals.
Pre/post assessment outcomes (if available)	Compliance	The discharge report summarizes pre/post assessment outcomes when available.
Aftercare referrals or follow-up recommendations	Compliance	The discharge report documents aftercare referrals and follow-up recommendations.
Discharge and Post-Assessment Documents & Required Discharge Documentation includes:		
30-day and 60-day follow-ups were completed using the SNAP® Contact Note format.	Compliance	30-day and 60-day post-discharge follow-ups are completed using the SNAP® Contact Note format.
Follow-up records were entered into NetMIS within three (3) business days of completion.	Compliance	Follow-up records are entered into NetMIS within three (3) business days of completion.
Additional Comments: There are no additional comments for this indicator.		
4.1 - SNAP® Fidelity Monitoring		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.1		Yes
		The agency has the required policy Section 400-4.1, SNAP Fidelity monitoring that was approved 12/1/2025 by the COO.
Additional Comments: There are no additional comments for this indicator.		
4.2 - SNAP® for Youth		Not Applicable
Provider has a written policy and procedure that meets the requirement for Indicator 4.2		N/A
		The provider is not contracted to provide SNAP for Youth Services.
A total of zero SNAP® for Youth file(s) were reviewed during this evaluation period. Of these, zero were open and zero were closed.		
Intake Documents Include the following (Before youth begins SNAP® group participation):		
SNAP® Youth Client File Checklist	Not Applicable	Crosswinds is not a SNAP for Youth program provider.
Florida Network Youth Screening Form	Not Applicable	Crosswinds is not a SNAP for Youth program provider.
Florida Network Community Counseling Intake Form	Not Applicable	Crosswinds is not a SNAP for Youth program provider.
SNAP Youth Intake Brief Screening Checklist (Teacher or Caregiver version)	Not Applicable	Crosswinds is not a SNAP for Youth program provider.
NIRVANA® Assessment	Not Applicable	Crosswinds is not a SNAP for Youth program provider.
Consent to Treatment and Participation in Research Form	Not Applicable	Crosswinds is not a SNAP for Youth program provider.
SNAP® for Youth Orientation Document	Not Applicable	Crosswinds is not a SNAP for Youth program provider.
Youth Goal Sheet	Not Applicable	Crosswinds is not a SNAP for Youth program provider.
How I Think Questionnaire (HIT)	Not Applicable	Crosswinds is not a SNAP for Youth program provider.

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

4.3 - SNAP® Youth Justice		Satisfactory with Exception(s)
Provider has a written policy and procedure that meets the requirement for Indicator 4.3		Yes
		The agency has the required policy Section 400-4.3, SNAP Youth Justice, that was approved 12/1/2025 by the COO.
A total of five SNAP® Youth Justice (12-19) file(s) were reviewed during this evaluation period. Of these, two were open and three were closed.		
Pre-Service Documentation, prior to beginning group services, must be in youth files and includes:		
SNAP® Youth Client File Checklist	Compliance	All required SNAP® Youth Client File Checklists were completed prior to service initiation.
Florida Network Youth Screening Form	Compliance	All required Florida Network Youth Screening Forms were completed prior to service initiation.
Florida Network Community Counseling Intake Form	Compliance	Florida Network Community Counseling Intake Forms were properly documented prior to beginning group services.
NIRVANA® Assessment	Exception	One file did not complete the NIRVANA at intake due to the youth being arrested, and did not follow up to complete it.
Consent to Treatment and Participation in Research Form	Compliance	Consent to Treatment and Participation in Research Forms were signed and dated before youth participation.
SNAP® Orientation Document	Compliance	SNAP® Orientation Documents were completed and included in the file before the first session.
Youth Goal Sheet	Compliance	Youth Goal Sheets were developed collaboratively and finalized prior to service delivery.
How I Think Questionnaire (HIT)	Compliance	How I Think Questionnaires (HIT) were administered within the required pre-service timeframe.
Social Skills Improvement System (SSIS) – Student Form	Compliance	Social Skills Improvement System (SSIS) – Student Forms were completed prior to program participation.
Social Skills Improvement System (SSIS) – Teacher/Adult Form	Compliance	Social Skills Improvement System (SSIS) – Teacher/Adult Forms were obtained within the required timeframe.
All NetMIS data entries related to intake must be completed within three (3) business days.	Compliance	All NetMIS intake data entries were completed within the required three (3) business days.
Group Delivery and Fidelity: A check-in call is conducted 24-72 hours prior to each session and documented.	Compliance	Pre-session check-in calls were completed and documented 24–72 hours prior to each session.
Group Delivery and Fidelity: There is evidence that the youth attended a total of thirteen (13) sessions.	Compliance	Youth successfully participated in the full thirteen (13) SNAP® sessions as scheduled.

Post-Session & Evaluation Activities: Weekly group attendance and any issues are reported to each youth's JPO and the local CPO via email correspondence.	Compliance	Weekly group attendance and relevant updates were consistently reported to each youth's JPO and local CPO via email.
Post-Session & Evaluation Activities: Attendance Logs are maintained for each session.	Compliance	Attendance logs were accurately maintained and available for all program sessions.
Discharge Requirements		
Discharge summary completed for youth, regardless of completion status.	Compliance	Discharge summaries were completed for all youth, regardless of program completion status.
NIRVANA completed at Discharge	Exception	One of three applicable youth was discharged without completion of a NIRVANA.
At least three (3) documented attempts must be made to collect post-assessment data.	Exception	There was no documented attempts to complete NIRVANA that was not completed at discharge.
Discharge Report Includes the Following:		
Reason for discharge	Compliance	Each discharge report clearly identifies the youth's reason for discharge.
Summary of services and goal progress	Compliance	Discharge reports include a comprehensive summary of services provided and progress toward goals.
Summary of pre/post test changes, if available	Compliance	Pre- and post-test results are summarized in the discharge report when available.
Aftercare recommendations or referrals	Compliance	Aftercare recommendations and referrals are documented to support ongoing success.
Post-Discharge Follow-Up Includes the following:		
The 30-day Post-Discharge Follow-up was completed.	Compliance	30-day post-discharge follow-ups were completed and documented as required.
The 60-day Post-Discharge Follow-up was completed.	Compliance	60-day post-discharge follow-ups were completed within the expected timeframe.
Follow-ups are documented using the SNAP Contact Note Format.	Compliance	All follow-ups were documented using the SNAP® Contact Note format.
30-day follow-up is entered into NetMIS within three (3) business days of each follow-up completion.	Compliance	30-day follow-up data were entered into NetMIS within three (3) business days of completion.
60-day follow-up is entered into NetMIS within three (3) business days of each follow-up completion.	Compliance	60-day follow-up data were entered into NetMIS within three (3) business days of completion.
Additional Comments: There are no additional comments for this indicator.		

4.5 - SNAP® for Schools and Communities		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.5		Yes
		The agency has the required policy Section 400-4.5, SNAP for Schools and Communities, that was approved 12/1/2025 by the COO.
There is evidence the Measure of Classroom Environment (MoCE)-Pre-session is completed before beginning SNAP® for Schools and Communities.	Compliance	The Measure of Classroom Environment (MoCE) pre-session assessment is completed prior to beginning the SNAP® for Schools and Communities program.
A Fidelity Adherence Checklist completed per classroom was verified in the file.	Compliance	A Fidelity Adherence Checklist is completed for each classroom and verified in the file as required.
Each group session is entered into NetMIS within 3 business days of the session.	Compliance	Each group session is entered into NetMIS within three (3) business days of completion.
There is evidence of the SNAP® for Schools & Communities Feedback Form completed by the supervisory adult responsible at the final group.	Compliance	The SNAP® for Schools and Communities Feedback Form is completed by the supervising adult responsible at the final group session.
Additional Comments: There are no additional comments for this indicator.		
Domain Five		
5.0 - Shelter Program Services		Limited
Provider has a written policy and procedure that meets the requirement for Indicator 5.0		Yes
		The agency has the required policy Section 500-5.1, Shelter Environment, that was approved 12/1/2025 by the COO.
Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal.	Compliance	Youth are engaged in meaningful, structured activities seven days a week during awake hours, minimizing idle time and promoting positive development.
At minimum one hour of physical activity is provided daily.	Compliance	A minimum of one hour of physical activity is provided to youth each day as part of the daily schedule.
Youth are provided the opportunity to participate in a variety of faith-based activities aligned with their preference or spiritual beliefs. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities.	Compliance	Youth are offered opportunities to participate in faith-based activities aligned with their personal beliefs, and non-punitive structured activities are provided for those who choose not to participate.
Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read.	Compliance	Daily programming includes scheduled time for homework completion, access to age-appropriate reading materials, and opportunities for quiet reading and learning.

Daily programming schedule is publicly posted and accessible to both staff and youth.	Compliance	The daily programming schedule is clearly posted in a public area and accessible to both staff and youth.
Formal and accessible grievance procedures for youth, including available grievance forms and a locked box, are accessible to youth in a common area.	Compliance	Formal and accessible grievance procedures are in place for youth, including the availability of grievance forms and a locked grievance box located in a common area.
Only the Program Director/Supervisor has access to and manages grievances unless it is toward themselves (which is escalated to higher leadership).	Compliance	Only the Program Director or Supervisor has access to and manages submitted grievances, unless the grievance concerns them, in which case it is escalated to higher leadership.
All grievances are resolved and documented by the Program Director within 72 hours. If this does NOT occur within the 72-hour period, there is sufficient documentation explaining the cause of the delay in resolution.	Exception	Twenty-three grievances that were submitted from July to December 1, 2025 were reviewed. Two of the 23 grievances were not resolved timely. The grievance submitted 8/30/25 was resolved 9/8/25, and one submitted on 10/21/25 did not have a resolution date. A review of logbook documentation for grievance box checks for the period of October 17 through October 31 shows inconsistent entries. No grievance box checks were documented on 10/20, 10/22, 10/23, and 10/24. Grievance box checks were documented on 10/21 for both 10/21 and 10/20. There was documentation the boxes were checked 10/29, 10/30, and 10/31. On 10/28, an entry was completed for that date and included a note indicating that staff checked for grievances from the previous day 10/27, rather than having a distinct entry for each day. Overall, while several days reflect proper documentation, there are gaps and inconsistencies that indicate the grievance box check logs were not completed consistently on a daily basis during this review period. For the period July 1, 2025, through January 8, 2026, a total of 135 grievance box checks were required to meet the Monday–Friday schedule. During this timeframe, only 57 grievance checks were documented.
Grievances are maintained on file for a minimum of one (1) year.☐	Compliance	Grievances are securely maintained on file for a minimum of one (1) year in accordance with program policy.
Additional Comments: There are no additional comments for this indicator.		
5.1 Shelter Environment		Limited
Provider has a written policy and procedure that meets the requirement for Indicator 5.1		Yes
		The agency has the required policy Section 500-5.1, Shelter Environment, that was approved 12/1/2025 by the COO.
The facility is clean, neat, and well-maintained.	Compliance	The facility is consistently clean, neat, and well-maintained throughout all areas.

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Furnishings shall be in good repair and maintained as needed.	Compliance	All furnishings are in good repair and suitable for use.
The program is free of insect infestation.	Compliance	The facility remains free of any insect infestation.
All bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, mildew and in good working order.	Compliance	Bathrooms and shower areas are clean, fully functional, odor-free, and maintained to high sanitary standards.
There is no graffiti on walls, doors, or windows.	Compliance	No graffiti or defacement is present on any walls, doors, or windows.
Lighting is adequate for tasks performed there.	Compliance	Lighting is sufficient and appropriate for all activities and workspaces.
Exterior areas are free of debris.	Compliance	Exterior areas are clear of debris and well-kept.
Grounds are free of hazards.	Compliance	Grounds are regularly inspected and free of hazards.
Dumpster and garbage can(s) are covered.	Compliance	Dumpsters and garbage cans are securely covered and properly maintained.
All doors are secure.	Compliance	All facility doors are secure and functioning properly.
In and out access is limited to staff members and key control is in compliance.	Compliance	Access to and from the facility is restricted to authorized staff, and key control procedures are followed in compliance with policy.
All agency and staff vehicles are locked. All agency vehicles are equipped with major safety equipment including first aid kit (with current, non-expired items that are replaced regularly), a fire extinguisher, a flashlight, a glass breaker, and seat belt cutter.	Exception	The program has two vans used to transport youth; however, one of the vans was not available for inspection as it was being serviced and held at the service shop. An inspection of the 2019 Honda Odyssey revealed the fire extinguisher in the vehicle was punched November 2024 and expired November 2025.
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 style="text-align: center;">Exception</p>	<p>Weekly count sheets for chemicals are completed consistently; however, a perpetual count log is not consistently maintained. Counts were only observed for the period from October 2, 2024, to November 15, 2024.</p>
<p>Material Safety Data Sheets (MSDS) are maintained on each chemical item.</p>	<p style="text-align: center;">Exception</p>	<p>During inspection of the chemicals, it was observed the MSDS for zep, bleach, and dawn were missing. The program obtained the documents during the review.</p>
<p>Washer/dryer are operational & general area/lint collectors are cleaned after ever load.</p>	<p style="text-align: center;">Compliance</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 style="text-align: center;">Compliance</p>	<p>Each youth is provided with an individual bed, clean mattress, pillow, and sufficient linens and blankets.</p>
<p>Youth have a safe, lockable place to keep personal belongings, if requested.</p>	<p style="text-align: center;">Compliance</p>	<p>Youth have access to a secure, lockable space for personal belongings upon request.</p>
<p>Fire Safety and Health Hazards</p>		
<p>An annual facility fire inspection was conducted, and the facility is in compliance with the local fire marshal and fire safety code within the jurisdiction.</p>	<p style="text-align: center;">Exception</p>	<p>The last annual Fire Inspection was conducted by Cocoa Fire Department on 12/3/2024, noting code violations. As of the QI visit, a current inspection was not completed. On 11/20/25, deficiencies were identified, including no audible sound, a damaged pull station, and an expired battery. Documentation was provided showing a change in service providers, transitioning from Wiginton to a new company for inspection and maintenance services. The annual fire inspection was delayed due to the pending repairs and work orders were submitted. Work orders were completed the week following the QI review and a satisfactory annual fire inspection was issued 1/20/2026 with no violations noted.</p>

<p>Agency completes at least one fire drill on each shift monthly and demonstrates they are within 2 minutes or less.</p>	<p>Exception</p>	<p>During the past six months, monthly fire drills were conducted on each shift as follows on 1st Shift: 7/21, 8/17, 9/23, 10/25, 11/22, and 12/23; 2nd Shift: 8/6, 9/3, 10/22, 11/26, and 12/21; and on 3rd Shift: 7/2, 8/2, 9/3, 10/8, 11/15, and 12/15. A review of fire drill documentation identified multiple instances of incomplete and non-compliant entries related to required time tracking and documentation standards. Not everyone evacuated on several dates for different reasons as follows: 7/2- due to safety (3rd shift); 7/21- page missing with number evacuated; 9/3 due to safety concerns (3rd shift); 10/8 due to safety concerns; 11/15 - due to lateness (3rd shift); and 12/15 - due to 3 youth being ill (3rd shift). Four drills were missing documented end times: 7/2 - 2nd shift, 8/2, 9/3 - 3rd shift, and 10/8. Evacuation time exceeded two minutes for four drills: 9/23, 11/22, 11/26, and 12/15. In November, a revised fire drill template was implemented, which included a reminder that the building must be cleared within two minutes or less. During this transition, there were entries where camera footage was reviewed and evacuation times were subsequently updated to reflect more accurate completion times. Additional documentation concerns were noted, including missing youth signatures on some fire drill logs and a lack of information regarding which staff completed the drill documentation.</p>
<p>Completes 1 mock emergency drill per shift quarterly, at a minimum.</p>	<p>Compliance</p>	<p>Mock emergency drills are held at least quarterly per shift, ensuring staff readiness and procedural compliance.</p>
<p>All annual fire safety equipment inspections are valid and up-to-date (building extinguishers, sprinklers, alarm systems, kitchen overhead hood, and fire extinguishers in all vehicles). Fire extinguishers are easily accessible in the event of an emergency and not locked away.</p>	<p>Exception</p>	<p>There were three fire extinguishers dated 11/2024 which expired 11/2025, including one in the vehicle that was on site.</p>
<p>The agency has a current Satisfactory Residential Group Care inspection report from the Department of Health.</p>	<p>Compliance</p>	<p>The facility maintains a current, satisfactory Residential Group Care inspection report from the Department of Health.</p>
<p>The agency has a current Satisfactory Food Service inspection report from the Department of Health, and food menus are posted, current and signed by a Licensed Dietitian annually.</p>	<p>Compliance</p>	<p>The program holds a valid, satisfactory Food Service inspection report from the Department of Health; menus are current, posted, and signed annually by a Licensed Dietitian.</p>

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All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored.	Compliance	Cold and dry food items are properly labeled, dated, and stored; pantry and storage areas are clean and organized.
Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.	Compliance	Refrigerators and freezers are clean, maintain required temperatures, and all appliances are operational and sanitary.
Additional Comments: There are no additional comments for this indicator.		
5.2 - Shelter Search Policy		Limited
Provider has a written policy and procedure that meets the requirement for Indicator 5.2		Yes
		The agency has the required policy Section 500-5.2 Shelter Search Policy, that was approved 12/20/2025 by the COO.
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.	Compliance	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.
Shelter staff conduct searches of outdoor recreational areas prior to youth using the area.	Exception	Environmental search checks were not observed in the documentation reviewed and there was no evidence recreational areas were searched prior to the use of outside spaces.
Shelter staff conduct frequent and random searches on each shift.	Exception	Room search and contraband documentation was reviewed. Room search forms reflect an entry dated 6/25/25, with the next recorded entry not occurring until 12/25. Contraband documentation shows several entries in September, followed by no additional entries until 12/18. These gaps indicate inconsistent documentation during the review period.
Additional Comments:		
Observation of the program's practice of youth search was conducted during the onsite review. The program utilizes an electronic wand to conduct youth searches. During the review, a staff member was observed performing a random youth search in accordance with program policy. The search was conducted in view of the camera and the youth was asked to empty their pockets and remove their shoes. The wand was passed over along the front and back of youth, from head to toe.		
5.3 - Logbook Requirements		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 5.3		Yes
		The agency has the required policy Section 500-5.3, Logbooks, that was approved 12/10/2025 by the COO.
Data sources Reviewed	Dates Reviewed	Logbook Format

Two consecutive weeks for each month, July – December, total of 6, 2-week periods.	7/1/2025 - 7/15/2025, 8/15/2025 - 8/29/2025, 9/7/2025 - 9/21/2025, 10/17/2025 - 10/31/2025, 11/1/2025 - 11/15/2025, 12/11/2025 - 12/25/2025	Electronic
The program has a process in place to document daily activities, events, and other major occurrences.	Compliance	The program maintains a consistent process to document daily activities, events, and major occurrences.
Safety and security issues that could impact the youth and/or program are highlighted.	Compliance	Safety and security issues that may impact the youth and/or program are clearly identified and highlighted.
All entries are brief and legibly written in ink for paper logbooks.	Not Applicable	The program uses an electronic log book.
All entries include: a. Time of incident/activity/event b. Names of youth and staff involved c. Brief statement providing pertinent information d. Signature of person making the entry	Compliance	All entries include the time of the incident or activity, names of youth and staff involved, a brief statement of pertinent information, and the signature of the person making the entry.
All recording errors are struck through with a clear line with staff initial and date.	Compliance	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.	Not Applicable	The program uses an electronic log book.
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.	Compliance	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.	Compliance	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.	Compliance	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.	Compliance	Supervision and resident counts are consistently documented.
Visitation and home visits are documented.	Compliance	Visitation and home visits are clearly documented.
Additional Comments: There are no additional comments for this indicator.		
5.4 - Staffing Standards and Enhanced Supervision		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 5.4		Yes
		The agency has the required policy Section 500-5.4, Staffing Standards and Enhanced Supervision, that was approved 12/24/2025 by the COO.
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.	Compliance	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.	Compliance	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.	Compliance	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.	Compliance	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.	Compliance	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.)	Compliance	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.

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<p>The program assigns specific staff during each shift to monitor the location, behavior, and movement of youth on enhanced supervision. The assignment of staff to youth on enhanced supervision status is documented in the shelter log and staff calendar.</p>	<p>Not Applicable</p>	<p>During the review period the program administrator reported there have not been any enhanced supervision youth in the program.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>5.5 - Behavior Management Strategies</p>		<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 5.5</p>	<p>Yes The agency has the required policy Section 500-5.5, Behavior Management, that was approved 11/1/2025 by the COO.</p>	
<p>A Behavior Management Strategy (BMS) is in place:</p>		
<p>The program has a detailed written description of the BMS and it is explained during program orientation.</p>	<p>Compliance</p>	<p>The program maintains a detailed written description of its Behavior Management Strategy (BMS), which is reviewed with youth during program orientation.</p>
<p>The written description of the behavioral management strategies include:</p>		
<p>A wide variety of positive incentives are used by the program.</p>	<p>Compliance</p>	<p>The written BMS outlines a wide variety of positive incentives used by the program to encourage appropriate behavior.</p>
<p>Appropriate interventions are used by the program to teach youth new behaviors and help youth understand the natural consequences for their actions.</p>	<p>Compliance</p>	<p>The BMS includes appropriate interventions designed to teach youth new skills and help them understand natural consequences for their actions.</p>
<p>Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior.</p>	<p>Compliance</p>	<p>Behavioral interventions are applied immediately, consistently, and proportionate to the severity of the behavior.</p>
<p>The Behavior Management Strategy includes:</p>		
<p>Consequences for violation of program rules are applied logically and consistently.</p>	<p>Compliance</p>	<p>Consequences for violations of program rules are applied logically, consistently, and fairly across all youth.</p>
<p>Program uses a variety of rewards/incentives to encourage participation and completion of the program.</p>	<p>Compliance</p>	<p>The program uses a variety of rewards and incentives to promote participation, engagement, and program completion.</p>
<p>All staff are trained in the theory and practice of administering BMS rewards and consequences.</p>	<p>Compliance</p>	<p>All staff are trained in both the theory and practical application of administering BMS rewards and consequences.</p>
<p>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.</p>	<p>Compliance</p>	<p>Supervisors are trained to monitor staff implementation of behavioral interventions, including point- or level-based systems when applicable.</p>
<p>There is a protocol for providing feedback and evaluation of staff regarding their use of the positive and negative consequences.</p>	<p>Compliance</p>	<p>The program has a clear protocol for providing feedback and evaluation to staff regarding their use of positive and negative consequences.</p>

In general, BMS promotes order, safety, security, respect, fairness, and protection of resident rights.	Compliance	The BMS promotes order, safety, security, respect, fairness, and protection of youth rights throughout the program environment.
BMS provides constructive discipline that encourages youth to meet behavior expectations.	Compliance	The BMS provides constructive discipline that encourages youth to meet and maintain behavioral expectations.
BMS provides for positive reinforcement & recognition; constructive dialogue & peaceful resolution; and minimizes separation of youth from the general population.	Compliance	The BMS emphasizes positive reinforcement, recognition, constructive dialogue, and peaceful conflict resolution while minimizing unnecessary separation from peers.
Disciplinary measures do not deny the youth any of the following: regular meals and snacks, clothing, sleep, physical or mental health services, educational services, exercise, correspondence privileges, or contact with parents/guardians, attorney of record, juvenile probation officer or clergy.	Compliance	Disciplinary measures never deny youth access to meals, clothing, sleep, healthcare, education, exercise, communication privileges, or contact with parents/guardians, attorneys, probation officers, or clergy.
Additional Comments: There are no additional comments for this indicator.		
5.6 - Program Orientation		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 5.6		Yes
		The agency has the required policy Section 500-5.6, Program Orientation, that was approved 11/1/2025 by the COO.
A total of five Program Orientation file(s) were reviewed during this evaluation period. Of these, two were open and three were closed.		
During the first 24 hours following admission, the program must begin the orientation process, to include:		
Youth received a comprehensive orientation and handbook provided within 24 hours.	Compliance	Youth receive a comprehensive orientation and handbook within the first 24 hours of admission in accordance with program policy.
Youth Orientation is discussed with the youth and includes the following:		
Youth are given a list of contraband items.	Compliance	Youth are provided with a list of contraband items and understand restrictions for safety and security.
Behavioral Expectations and a review of the BMS	Compliance	Behavioral expectations are reviewed in detail, including an explanation of the program's Behavior Management Strategy (BMS).
Dress code explained	Compliance	The program's dress code is explained to youth during orientation.
Review of access to medical and mental health services	Compliance	Youth are informed of available medical and mental health services and how to access them.
Procedures for visitation, mail and telephone	Compliance	Procedures for visitation, mail, and telephone use are reviewed with youth during orientation.
Grievance procedure	Compliance	The program's grievance procedure is explained, including how to file a grievance and access grievance forms.
Disaster preparedness instructions	Compliance	Youth receive disaster preparedness instructions and understand emergency procedures.

Physical layout of the facility	Compliance	Youth are oriented to the physical layout of the facility, including key safety areas and exits.
Sleeping room assignment and introductions	Compliance	Sleeping room assignments are reviewed, and youth are introduced to peers and staff as part of the orientation process.
Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	Compliance	Youth receive suicide prevention information, including how to alert staff if they or others experience suicidal thoughts.
Review of program schedule	Compliance	The daily program schedule is reviewed with youth to promote understanding of structure and expectations.
Additional Comments: There are no additional comments for this indicator.		
5.7 - Youth Room Assignment		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 5.7		Yes
		The agency has the required policy Section 500-5.7, Room Assignment that was approved 11/7/2025 by the COO.
A total of five Youth Room Assignment file(s) were reviewed during this evaluation period. Of these, two were open and three were closed.		
The program determines room assignments during admission and intake using the following indicators:		
Review of youth’s history, status & exposure to trauma	Compliance	Youth classification includes a thorough review of the youth’s history, current status, and exposure to trauma to ensure safe and appropriate placement.
Collateral contacts	Compliance	Staff make collateral contacts, as needed, to gather additional information relevant to youth classification and safety.
Initial interactions with and observations of the youth	Compliance	Initial interactions and staff observations of the youth are used to inform room assignments and supervision levels.
Separation of younger youth from older youth	Compliance	Younger youth are housed separately from older youth to promote safety and developmental appropriateness.
Separation of violent youth from non-violent youth	Compliance	Youth with a history of violent behavior are separated from non-violent youth to reduce risk and maintain safety.
Identification of youth susceptible to victimization	Compliance	Youth identified as susceptible to victimization are assigned rooms that promote protection and increased supervision.
Presence of medical, mental, or physical disabilities	Compliance	Youth with medical, mental health, or physical disabilities are appropriately classified to ensure their needs are safely accommodated.
Suicide risk	Compliance	Youth are screened for suicide risk upon admission, and any identified concerns are addressed immediately through safety planning and supervision.
Sexually aggressive and predatory behavior	Compliance	Youth exhibiting sexually aggressive or predatory behaviors are identified and separated to maintain the safety of others.

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Acute health symptoms requiring quarantine or isolation	Compliance	Youth presenting acute health symptoms are appropriately quarantined or isolated in accordance with health and safety protocols.
An alert is immediately entered into the program’s alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors.	Compliance	Alerts are immediately entered into the program’s alert system for youth with special needs or risks, including suicide risk, mental health, substance abuse, medical, or security concerns.
Additional Comments: There are no additional comments for this indicator.		
5.8 - Video Surveillance		Satisfactory with Exception(s)
Provider has a written policy and procedure that meets the requirement for Indicator 5.8	Yes	
	The agency has the required policy Section 500-5.8, Video Surveillance, that was approved 12/6/2025 by the COO.	
The agency has a system in operation 24 hours a day, 7 days a week. Does it demonstrate:		
A written notice that is conspicuously posted on the premises for the purpose of security.	Compliance	A written notice indicating video surveillance for security purposes is conspicuously posted on the premises.
Cameras are in the interior (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit (including locations where youth searches are conducted).	Compliance	Cameras are positioned in key interior areas (e.g., intake office, counseling rooms, cafeteria, and dayroom) and exterior locations (e.g., entrances, exits, recreation areas, and parking lots) where youth, staff, and visitors congregate or pass through.
All cameras are visible.	Compliance	All cameras are clearly visible and serve as an effective deterrent to unsafe or prohibited behavior.
No cameras are placed in bathrooms or sleeping quarters.	Compliance	Cameras are not placed in bathrooms or sleeping quarters, ensuring the privacy and dignity of youth and staff.
The system can capture and retain video photographic images, which must be stored for a minimum of 30 days.	Compliance	The video surveillance system captures and retains recordings for a minimum of 30 days in compliance with program requirements.
The system can record date, time, location, and maintain a resolution that enables facial recognition.	Compliance	The system records date, time, and location, maintaining sufficient resolution to enable facial recognition when needed.
Cameras can operate during a power outage.	Compliance	Cameras and recording equipment remain operational during power outages, supported by backup systems.
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel).	Compliance	A current list of designated personnel authorized to access the surveillance system, including off-site access permissions, is maintained and up to date.

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<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 a random sample of overnight shifts.</p>	<p>Exception</p>	<p>Video reviews are being conducted; however, the schedule is not consistent with the 14-day requirement. Several reviews are either too far apart or too close together, including gaps of 21 days (7/31–8/21), 26 days (9/4–9/30), 1 day (10/18–10/19), and 30 days (11/11–12/11). While reviews are occurring, the timing does not align with policy. While supervisory reviews of video footage are not conducted consistently, the Compliance Administrator conducts reviews frequently and provides valuable, constructive feedback to the program.</p>
<p>Requests for video recordings pursuant to investigations or quality improvement visits are provided within 24-72 hours of the request.</p>	<p>Compliance</p>	<p>The agency has a policy that 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>Compliance</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>Additional Comments: There are no additional comments for this indicator.</p>		
<p>Domain Six</p>		
<p>6.0 - Medication Management and Distribution</p>		<p>Satisfactory with Exception(s)</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 6.0</p>	<p>Yes</p> <p>The agency has the required policy Section: 600-6.0, Medication Management and Distribution, that was approved 12/24/2025 by the COO.</p>	
<p>A total of three Medication Management and Distribution file(s) were reviewed during this evaluation period. Of these, one were open and two were closed.</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>Compliance</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:</p> <ul style="list-style-type: none"> a. provided by a Registered Nurse b. demonstrate competency c. maintain re-certification annually 	<p>Compliance</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>

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<p>There is evidence of, at least, quarterly staff meetings conducted by RN and/or Shelter Manager to:</p> <ul style="list-style-type: none"> a. review and assess strategies implemented to reduce medication errors shelter wide b. analyze factors that contributed to medication errors c. allow staff the opportunity to practice and role-play solutions 	<p>Compliance</p>	<p>Quarterly staff meetings led by the RN and/or Shelter Manager are conducted to review medication error trends, analyze contributing factors, and practice strategies for prevention through discussion and role-play.</p>
<p>Any (non-nursing) staff member responsible for assisting with the self-administration of medications is clearly identified and designated on the staff schedule and shift change report/shift responsibility form on each shift.</p>	<p>Compliance</p>	<p>Staff authorized to assist with medication distribution are clearly designated on the staff schedule and shift responsibility forms for every shift.</p>
<p>The program has strategies to ensure medications are provided within the time frame.</p>	<p>Compliance</p>	<p>The program has established procedures to ensure medications are administered within required timeframes.</p>
<p>The agency has a clear method of communicating which youth are on medications with the times and dosage easily discernible by all staff on each shift.</p>	<p>Compliance</p>	<p>A clear communication system is maintained to ensure staff on each shift can easily identify youth medication schedules, including times and dosages.</p>
<p>Any staff member deemed responsible for a medication error, received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. An RN from another Florida Network shelter may be engaged to provide the refresher training virtually if an RN is not currently on staff, with Florida Network approval.</p>	<p>Compliance</p>	<p>Staff responsible for a medication error receive refresher training from an RN and must demonstrate competency before resuming medication administration duties.</p>
<p>For any staff member deemed responsible for 3 errors within a 1-year time frame, their certification is suspended. Staff were ONLY recertified after completing a full in-person medication administration training, demonstrating competency and receiving certification from the RN.</p>	<p>Compliance</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>Compliance</p>	<p>All medications, including controlled substances, are securely stored in a Pyxis ES Medication Cabinet that is inaccessible to youth.</p>

<p>Pyxis machine stored in accordance with guidelines in Florida Statute 499.0121 and policy section Medication Management. FS 499.0121 states the establishment where medications are stored must:</p> <p>(a) Be of suitable size and construction to facilitate cleaning, maintenance, and proper operations;</p> <p>(b) Have storage areas designed to provide adequate lighting, ventilation, temperature, sanitation, humidity, space, equipment, and security conditions;</p> <p>(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;</p> <p>(d) Be maintained in a clean and orderly condition; and</p> <p>(e) Be free from infestation by insects, rodents, birds, or vermin of any kind.</p>	<p>Compliance</p>	<p>The Pyxis machine and medication storage area meet all conditions outlined in Florida Statute 499.0121, ensuring cleanliness, security, proper ventilation, temperature control, and pest-free conditions.</p>
<p>Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station.</p>	<p>Compliance</p>	<p>The agency maintains a minimum of two site-specific Pyxis ES System Managers to ensure continuous oversight and accountability.</p>
<p>Oral medications are stored separately from injectable or topical medications.</p>	<p>Compliance</p>	<p>Oral medications are stored separately from injectable and topical medications to prevent cross-contamination.</p>
<p>Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose.</p>	<p>Compliance</p>	<p>Medications requiring refrigeration are stored in a secure, designated refrigerator or within a secured room inaccessible to youth.</p>
<p>Temperature requirements are 2-8 degrees C or 36-46 degrees F for storage of medications.</p>	<p>Compliance</p>	<p>Medication refrigeration units are consistently maintained at 2–8°C (36–46°F) to meet temperature requirements.</p>
<p>Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics).</p>	<p>Compliance</p>	<p>Only authorized staff listed in User Permissions have access to secured medications, with restricted access to controlled substances.</p>
<p>Perpetual inventory with running balances are maintained for controlled substances.</p>	<p>Exception</p>	<p>Nine of ninety-two shift-to-shift inventory counts across three youth medication records reviewed were missing perpetual counts.</p>
<p>Shift-to-shift counts (verified by a witness and is documented) are conducted and documented for controlled substances.</p>	<p>Exception</p>	<p>Twenty of ninety-two shift-to-shift inventory counts across three youth medication records were not completed as required. Some were missing medication receipts, date of receipt, chain of custody, or witness signatures.</p>

<p>Non-controlled medication and over-the-counter medications that are accessed regularly are inventoried weekly.</p>	<p>Compliance</p>	<p>Regularly accessed non-controlled and over-the-counter medications are inventoried weekly to ensure proper tracking.</p>
<p>Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly.</p>	<p>Not Applicable</p>	<p>According to the nursing staff, the program does not have any sharps or syringes to include not epi-pen on-site.</p>
<p>There are monthly reviews of Pyxis Reports to monitor medication management practice.</p>	<p>Compliance</p>	<p>Monthly Pyxis reports are reviewed to monitor medication management practices and identify any trends requiring corrective action.</p>
<p>Medication is verified using one of the three methods outlined in Policy 4.02: 1. Contact Pharmacy 2. Registered Nurse or Licensed Practical Nurse 3. Pill Identifier (Pill Finder) – Drugs.com</p>	<p>Compliance</p>	<p>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.</p>
<p>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.</p>	<p>Compliance</p>	<p>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.</p>
<p>The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy.</p>	<p>Compliance</p>	<p>The medication delivery process fully aligns with Florida Network’s Medication Management and Distribution Policy.</p>
<p>All discrepancies are cleared each shift.</p>	<p>Compliance</p>	<p>All medication discrepancies are identified, reviewed, and cleared at the end of each shift.</p>
<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>Compliance</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>Compliance</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>Exception</p>	<p>Medication records for three youth were reviewed. Three of eleven distribution records for one youth did not have the youth's initial. Two of three medication receipts do not have the date, chain of custody, or witness signatures.</p>

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<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 style="text-align: center;">Exception</p>	<p>Three youth medication records reviewed indicated one youth's documentation was missing one of seven medication pass time on the MDR. Another youth was missing one of nineteen time documentation, and one of nineteen medication administration was given outside of the proper time frame. Two of forty-four time documentation was missing on the MDR for the third youth.</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 style="text-align: center;">Compliance</p>	<p>Upon admission, youth and parents or guardians are interviewed regarding current medications as part of the Medical and Mental Health Assessment, conducted by the Registered Nurse or is reviewed by a Registered Nurse within three business days.</p>
<p>Upon intake/admission of a youth, an on-shift certified supervisor of higher level staff will review all medication forms on the next business day. In the event the agency does not have a Registered Nurse, the medication review will be conducted by a certified Leadership position.</p>	<p style="text-align: center;">Compliance</p>	<p>All medication forms are reviewed by a certified supervisor or leadership-level staff member on the next business day following youth intake, ensuring proper oversight and compliance with medication procedures.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		
<p>A medication pass was observed. The nurse brought the youth to the nursing office to administer the medication. The nurse verified the youth's name, date of birth, and asked the youth what medication they take. After the verification, the nurse dispensed the medication from the Pyxis machine, placed the medication in a cup, and handed the cup to the youth. The youth was observed by the nurse to place the medication in their mouth, and then the nurse poured water into the cup for the youth to take the medication. The youth drank the water and took the medication. The nurse verified the medication was not in the youth's mouth by asking them to open their mouth, move their tongue, and cough in their sleeve. The youth was returned to the group.</p>		
<p>6.1 - Naloxone Administration and Opioid Overdose Response</p>		<p style="text-align: center;">Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 6.1</p>		<p>Yes The agency has the required policy Section: 600-6.1, Naloxone Administration and Opioid Overdose Reponse, that was approved 12/1/2025 by the COO.</p>
<p>Naloxone is stored between 37 and 77 degrees F and is stored with a cold pack when transported in vehicles to maintain effectiveness.</p>	<p style="text-align: center;">Compliance</p>	<p>Naloxone is securely stored at appropriate temperatures between 37°F and 77°F, and cold packs are used during vehicle transport to ensure medication stability and effectiveness.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		

6.2 - Suicide Prevention		Satisfactory with Exception(s)
Provider has a written policy and procedure that meets the requirement for Indicator 6.2		Yes
		The agency has the required policy Section: 600-6.2, Suicide Prevention, that was approved 12/26/2025 by the COO.
Shelter maintains a written suicide prevention & response plan approved by the Florida Network.		Yes
SNAP maintains a written suicide prevention & response plan approved by the Florida Network.		Yes
Community Counseling maintains a written suicide prevention & response plan approved by the		Yes
Upon intake, every youth is screened for suicidality using the five Florida Network questions.	Compliance	All youth are consistently screened for suicidality during intake using the five Florida Network questions.
Screening results are reviewed, signed by a supervisor, and filed in the youth's case record.	Compliance	Screening results are reviewed, signed by a supervisor, and accurately filed in each youth's case record.
A "yes" to any question triggers a full suicide risk assessment by: 1. A Licensed Mental Health Professional (LMHP), or 2. A non-licensed clinician under direct LMHP supervision.	Compliance	All screens that triggered a positive response for suicide risk demonstrated that a full suicide risk assessment was completed by a qualified LMHP or a clinician under direct LMHP supervision.
Assessment of Suicide Risk must be completed and reviewed by the LMHP within 24 hours of a positive screen.	Exception	One youth was screened on 10.31.2025 and had a hit. The Assessment of Suicide Risk (ASR) was not conducted until 11.03.2025, 2 days late.
All assessments (initial and follow-up) are documented in detail: youth comments, behaviors, observations, risk indicators, supervision recommendations, treatment/follow-up, and signed and dated by the LMHP.	Compliance	Assessments are thoroughly documented, capturing all relevant observations, youth statements, risk indicators, and follow-up actions, with proper LMHP signature and date.
If conducted by a non-licensed staff member, the LMHP must co-sign and date as reviewer the next time they are on-site.	Not Applicable	All six ASR reviewed were completed and signed by the LMHP.
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.	Compliance	Parents/guardians and program supervisors are notified immediately of any youth at risk, and all contact efforts are well-documented in the case file.
If a youth poses an immediate threat to self or others at any time, staff follow Baker Act protocols and/or call 911.	Not Applicable	None of the six ASR reviewed indicated youth was as an immediate threat to self or others.
Documentation & Family Notification		
All screenings, assessments, supervision actions, and shift-to-shift handoffs are logged in the daily shelter/counseling logbook.	Compliance	All screenings, assessments, supervision activities, and shift-to-shift handoffs are clearly recorded in the daily logbook.

<p>If a guardian cannot be reached in person, telephone contact attempts are documented; and written notice is sent by certified mail.</p>	<p>Not Applicable</p>	<p>Parent notification was observed for all six records reviewed.</p>
<p>When an immediate assessment is not possible, families receive community resource information.</p>	<p>Not Applicable</p>	<p>An immediate assessment was made for five of six suicide risk youth. One residential youth's assessment occurred 2 days late; however the youth was placed on constant sight and sound until assessed by the LMHP.</p>
<p>Community Counseling Only: Any screening conducted on school property during school hours is reported to appropriate school authorities.</p>	<p>Not Applicable</p>	<p>None of the community counseling suicide risk screenings reviewed were conducted on school property.</p>
<p>Residential Only: Youth with a positive suicide screen are placed on Constant Sight & Sound Supervision until assessed by a licensed professional or non-licensed professional under the direct supervision of the licensed professional.</p>	<p>Compliance</p>	<p>Youth with a positive suicide screen are immediately placed on Constant Sight and Sound Supervision until assessment by a qualified professional occurs.</p>
<p>Residential Only: Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.</p>	<p>Compliance</p>	<p>Youth are consistently placed on the appropriate supervision level according to suicide risk assessment results.</p>
<p>Residential Only: Staff document observations (time, behavior notes, warning signs, initials) at intervals no longer than 30 minutes.</p>	<p>Compliance</p>	<p>Staff maintain detailed observation logs every 30 minutes, noting time, behavior, warning signs, and initials.</p>
<p>Residential Only: The assigned supervision level remains in place until a follow-up assessment by an LMHP (or supervised unlicensed clinician) confirms safety or the youth is diverted via Baker Act.</p>	<p>Compliance</p>	<p>The assigned supervision level remains active until a follow-up assessment by an LMHP (or supervised clinician) confirms safety or the youth is diverted per Baker Act procedures.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>		

6.3 - Healthcare Admission Screening		Limited
Provider has a written policy and procedure that meets the requirement for Indicator 6.3		Yes The agency has the required policy Section: 600-6.3, Healthcare Admission Screening, that was approved 12/24/2025 by the COO.
A total of five Healthcare Admissions Screening file(s) were reviewed during this evaluation period. Of these, two were open and three were closed.		
The primary healthcare screening is completed by the nurse if he/she is present during the intake. If not present during the intake, the nurse reviews the primary healthcare screening within 3 business days.	Exception	None of the five reviewed records contained documentation of the nursing staff's acknowledgement of the healthcare screening questions on the Residential Intake Form due to nurse vacancies. The program has had nursing vacancies throughout the review period as a result of decisive corrective actions to fully resolve multiple healthcare administration issues that were uncovered around medication errors. The CEO provided documentation to support the corrective actions that were implemented including personnel corrective actions for three youth specialists and the registered nurse, revision of the agency's healthcare administration policy and healthcare screening forms, revision of the nurses job description, request and fulfillment of an onsite program review and assessment by another provider's registered nurse, and onsite retraining of Crosswind staff by Florida Network's (FN) provided nurse. The CEO communicated and consulted the FN to define the best practices including recruitment and qualification of potential candidates and successfully filled the nurse position on December 16, 2025.
The primary healthcare screening and observations include:		
Current medications	Exception	None of the five reviewed records had the youth's current medications listed on Intake Form as required.
Existing (acute and chronic) medical conditions	Compliance	Existing acute and chronic medical conditions are accurately identified and recorded.
Allergies	Compliance	Any allergies are clearly documented during the screening process.
Recent injuries or illnesses	Compliance	Recent injuries or illnesses are reviewed and noted as part of the assessment.
Observation for evidence of illness, injury, pain or physical distress, difficulty moving, etc.	Compliance	Staff document careful observations for signs of illness, injury, pain, physical distress, or mobility difficulties.
Acute health symptoms requiring quarantine or isolation	Compliance	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.	Compliance	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.	Compliance	The program has established procedures to ensure youth with chronic medical conditions receive appropriate medical referrals and follow-up care. Any medical needs that are identified at admission receive the appropriate referrals as required.
All medical referrals are documented on a daily log.	Compliance	All medical referrals are documented daily in the log as required.
Additional Comments: There are no additional comments for this indicator.		
6.4 - Medical/Mental Health Alert Process		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 6.4	Yes	
	The agency has the required policy Section: 600-6.4, Medical/Mental Health Alert Process, that was approved 12/06/2025 by the COO.	
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.		
If youth has a medical or mental health condition or allergies, they are appropriately placed on the program’s alert system.	Compliance	Youth with medical or mental health conditions or allergies are appropriately flagged in the program’s alert system to ensure staff awareness and safety.
Alert system includes precautions concerning prescribed medications and potential side effects.	Compliance	The alert system includes detailed precautions regarding prescribed medications and their potential side effects.
Staff are provided sufficient information/ instructions to recognize/respond to the need for emergency care for medical/mental health problems.	Compliance	Staff receive clear information and instructions enabling them to recognize and appropriately respond to medical or mental health emergencies.
A medical and mental health alert system is in place that ensure information concerning a youth’s medical condition, allergies, common side effects of prescribed medication, foods and medications that are contraindicated, or other pertinent mental health treatment information is communicated to all staff.	Compliance	A comprehensive medical and mental health alert system is in place, ensuring that all relevant information, including allergies, medication contraindications, and treatment considerations, is effectively communicated to all staff.
Additional Comments: There are no additional comments for this indicator.		