



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

**Florida Keys Children's Shelter**

73 High Point Road Tavernier, Florida 33070

**January 28-29, 2026**

**Compliance Monitoring Services Provided by**



## EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the Florida Keys Children's Shelter for the FY 2025-2026 at its program office located at 73 High Point Road Tavernier, Florida 33070. 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. Florida Keys Children's Shelter 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 Andrea Dean, Consultant for Forefront LLC. Agency representatives from Andrea Dean present for the entrance interview were: Ben Kemmer/ CEO, George Crume/ Community-based Counselor, Emily Cassis/ Community-based Counselor, Kim Youngblood/ Community-based Counselor, Anais Diaz/ Community Development and Outreach Director, Maile Horn/ Residential Coordinator, Kayla Clark/ Counseling Coordinator, Karen Martinez/ Residential Specialist, Nathaly Milla/ Training and Quality Compliance Manager, and Katya Andrade/ Office Manager. The last onsite QI visit was conducted on December 18-19, 2024.

In general, the Reviewer found that the Florida Keys Children's Shelter is in compliance with specific contract requirements. **Florida Keys Children's Shelter received an overall compliance rating of 100% for achieving full compliance with 13-ndicators** of the CINS/FINS Monitoring Tool. There were no recommendations or corrective actions as a result of the monitoring visit.

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

## 2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL

Report Number: CM 1-28-29-2026

<b>Agency Name: Florida Keys Children’s Shelter</b>					<b>Monitor Name: Andrea Dean, Lead Reviewer</b>		
<b>Contract Type: CINS/FINS</b>					<b>Region/Office: 73 High Point Road, Tavernier, FL 33070</b>		
<b>Service Description: Comprehensive Onsite Compliance Monitoring</b>					<b>Site Visit Date(s): January 28-29, 2026</b>		
<b>Major Programmatic Requirements</b>	<b>Explain Rating</b>					<b>Ratings Based Upon:</b> I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	<b>Notes</b>  <b>Explain Unacceptable or Conditionally Acceptable:</b>
	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable		
<b>I. Administrative and Fiscal</b>							
<b>DJJ Quality Improvement Peer Reviewer</b> a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency currently has three certified peer reviewers: Nathaly Milla/Training and Quality Compliance Manager, Kayla Clark/Counseling Supervisor, and Karen Martinez/Residential Specialist. The agency is scheduled to complete two reviews this fiscal year.	
<b>Additional Contracts</b> a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. <b>PTV</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency reports revenue for this fiscal year from the following sources: Monroe County, Sheriff Asset Forfeiture Fund, Key West Housing (In-kind), National School Lunch Program, Department of Children and Families, Basic Center Grant, Outreach Grant, Transitional Living Program Grant, Keys Children’s Foundation, Helen’s Hope Foundation, Ocean Reef Community Foundation, Katherine Wells Foundation, Community Foundation of the Florida Keys, Unrestricted Contributions Unrealized Gains, Klaus Murphy, Baptist Health, and United Way.	

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	<b>Unacceptable</b>	<b>Conditionally Acceptable</b>	<b>Fully Met</b>	<b>Exceeded</b>	<b>Not Applicable</b>		
<b>Limits of Coverage</b> a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker’s Compensation and Employer’s liability insurance as required by Chapter 440, F.S. with a minimum of \$100,000 per accident, \$100,000 per person and \$500,000 policy aggregate. Commercial General Liability with a limit of \$500,000 per occurrence, and \$1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of \$250,000 per person; with a minimum limit for bodily injury of \$500,000 per accident; with a minimum limit for property damage of \$100,000 per accident and with a minimum limit for medical payments or \$5,000-\$10,000 per person. Florida Network is listed as payee or co-payee. <b>PTV</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A review of the agency’s certificate of insurance dated 05/29/2025 verifies the program has the following minimum kinds of insurance: Worker’s Compensation and Employer’s liability insurance with limits of \$2,000,000 per accident, \$2,000,000 per person and \$2,000,000 policy aggregate, Commercial General Liability with limits of \$1,000,000 per occurrence, \$1,000,000 damages to rented premises, \$10,000 medical expense to any one person, \$1,000,000 personal and advanced injury, \$3,000,000 products aggregate and \$3,000,000 general aggregate, Automobile Liability with limits of \$1,000,000 single combined limit and \$1,000,000 bodily injury.  The Florida Network of Youth and Family Services is listed as a certificate holder.	
<b>External/Outside Contract Compliance</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	The agency reports no corrective action items cited by an external source (fiscal or non-fiscal).	

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a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). <b>ON SITE</b>							
<b>Fiscal Practice</b> a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. <b>PTV</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Observation of the agency’s fiscal reports and interview with the CEO and COO indicates the agency has sound internal controls. The agency has written employee and fiscal policies/procedures manuals that are in compliance with GAAP, and the agency maintains fiscal files that are audit ready.	
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). <b>PTV</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A review of the agency’s general ledger from July 1, 2025, through January 22, 2026, shows that the general ledger is set-up to track activities of the grant separately.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management. <b>-ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The Residential Coordinator maintains an \$800 petty cash fund which is replenished every three months. Expenses paid out of petty cash include youth allowances, youth grooming and hygiene needs, medications (when necessary), outings, and other misc. expenses. Petty cash receipts are reconciled by	

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						the Office Manager and reviewed by the COO for approval and reimbursement.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted monthly with supporting documentation and documentation provided contained 2 signatures. (Disbursements/invoices are approved and monitored by management. <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bank reconciliation statements from June 2025 through November 2025 were reviewed. Bank statements are reconciled within six weeks of receipt by a third-party bookkeeper, Summersgill, CPA. The agency’s office manager posts all expenses into QuickBooks, and the COO posts all revenue. The bank statements are reconciled by Summersgill and sent to the COO and CEO for review and approval. Internal invoices are reconciled and paid timely by the COO. All fiscal reports are prepared monthly by the COO and reviewed by the CEO, then presented to the Board of Directors for approval.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over \$1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. <b>PTV/ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	The agency reports that there is no inventory purchased with DJJ funds.	

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<b>Major Programmatic Requirements</b>	<b>Unacceptable</b>	<b>Conditionally Acceptable</b>	<b>Fully Met</b>	<b>Exceeded</b>	<b>Not Applicable</b>	<b>Ratings Based Upon:</b> <b>I = Interview</b> <b>O = Observation</b> <b>D = Documentation</b> <b>PTV = Submitted Prior To Visit</b> <b>(List Who and What)</b>	<b>Notes</b>  <b>Explain Unacceptable or Conditionally Acceptable:</b>
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), <u>Employee</u> IRS Form W-2 and <u>Independent Contractors</u> IRS Form 1099 forms prior to federal requirements. <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A review of the agency’s 941 reports shows the agency submits payroll taxes via ADP payroll service. Quarterly report from period ending June 30, 2025, was completed on 07/31/2025 and quarterly report for period ending September 2025 was completed 10/31/2025. ADP is responsible for filing and electronic submission of all tax reports and corresponding deposits.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. <b>PTV/ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interview with the COO reports that budgets are prepared annually, reviewed with the CEO, and presented to the Board of Directors for approval. Monthly profit and loss statements are prepared with a comparison to prior fiscal year.	
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 an extension has been requested and	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A review of the most recent audit report was dated March 17, 2025, for the period ending June 30, 2024, and 2023. The report was prepared by Verdeja Alvarez, Certified Public Accountants and Advisors. Section IV of the audit report states: 1. No management letter issued for the year	

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approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. <b>Can obtain from FNYFS</b>					ended June 30, 2024, because there were no findings required to be reported in the management letter. 2. No Summary Schedule of Prior Audit Findings is required because there was no prior audit findings related to state projects. 3. No corrective action plan is required because there were no findings required to be reported under the Florida Department of Financial Services’ State Projects Compliance Supplemental. The COO reported the audit for fiscal year ended June 30, 2025, which is close to completion. All functional expenses have been given to the accountant, and the accountant is awaiting confirmations from various funders. Observation of email correspondence from the Florida Network’s Contracts Team, dated 01/22/2026, to the COO shows the program’s audit is due to the Network by March 31, 2026.	

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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. <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency maintains written policies: 1.04 Computer Back-up, 5.05 Disposal of Property, Plant and Equipment, and 8.04 Records Retention and Storage, all approved by the CEO on 5/2/23. Additionally, policy 1.16 (Confidentiality-HIPAA), E.2 (Confidentiality), and 1.26 (Client Records) were reviewed. Daily back-ups are made to keep data back-up current and monthly off-site storage of the back-up disk is maintained.	
j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least \$19.00 per hour. This also includes funding for additional staff as approved by the Department. <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Review of the agency’s ADP payroll register dated 01/18/26 from period ending 01/18/26, shows evidence of every direct care staff currently being paid at least \$19.00 per hour.	
<b>Disaster Planning</b> k. The agency has a written policy and procedure that includes a policy title/number, date of last review/revision, meets all the requirements for the indicator that has been approved. The agency has a comprehensive Disaster Preparedness Plan that includes the following: o Emergency evacuation protocols o Severe weather procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency has a written emergency preparedness plan last updated 06/04/2025 which is approved annually. The agency’s plan includes the following: o Emergency evacuation protocols o Severe weather procedures o Evacuation logistics (shelter only)	

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				<b>Not Applicable</b>		
<ul style="list-style-type: none"> <li>o Evacuation logistics (shelter only)</li> <li>o Evacuation facility designation (shelter only)</li> <li>o Critical Resource Planning</li> <li>o Florida Network and DJJ notification requirements</li> </ul> The Universal Agreement/Emergency Disaster Shelter document is signed by the agency executive. The comprehensive Disaster Preparedness Plan is submitted to the Florida Network annually, no later than February 1st. <b>ON SITE</b>					<ul style="list-style-type: none"> <li>o Evacuation facility designation (shelter only)</li> <li>o Critical Resource Planning</li> <li>o Florida Network and DJJ notification requirements</li> </ul> The Universal Agreement/Emergency Disaster Shelter document is signed by the agency executive and uploaded to the HUB platform of the Florida Network.	

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**CONCLUSION**

The Florida Keys Children’s Shelter has met the requirements for the CINS/FINS contract as a result of full compliance with 13 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the fifteen indicators were not applicable because the agency reports no corrective action items cited by an external source (fiscal or non-fiscal) and the agency reports there is no inventory purchased with DJJ funds. 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.

**SUMMARY OF CORRECTIVE ACTIONS or RECOMMENDATIONS**

**Corrective Action**

None

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



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

Review of Florida Keys Children's Shelter  
CINS/FINS Program

Date: January 28-29, 2026

Compliance Monitoring Services Provided by



## CINS/FINS Rating Profile

### Domain 1: Background Screening and Compliance

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

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

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

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

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

### Domain 4: SNAP® Programs

<b>4.0 SNAP® Under 12</b>	<b>Not Applicable</b>
<b>4.1 SNAP® Fidelity Monitoring</b>	<b>Not Applicable</b>
<b>4.2 SNAP® for Youth</b>	<b>Not Applicable</b>
<b>4.3 SNAP® Youth Justice</b>	<b>Not Applicable</b>
<b>4.5 SNAP® for Schools and Communities</b>	<b>Not Applicable</b>

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

Domain 5: Shelter Program Services

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

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

Domain 6: Medication Management

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

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

**Overall Rating Summary**

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

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### Rating Definitions

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

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

### Reviewers

#### Members

Andrea Dean - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services

Rondarrel George – Regional Monitor, Department of Juvenile Justice

LaShonda Chavis – Miami Bridge

Duane Gross – CHS Safe Harbor

Theresa Clove – THAISE

January 28-29, 2026

**Methodology**

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

**Persons Interviewed**

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

**Documents Reviewed**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Accreditation Reports                        | <input checked="" type="checkbox"/> Table of Organization            | <input checked="" type="checkbox"/> Visitation Logs       |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input type="checkbox"/> Fire Prevention Plan                        | <input checked="" type="checkbox"/> Youth Handbook        |
| <input checked="" type="checkbox"/> CCC Reports                       | <input checked="" type="checkbox"/> Grievance Process/Records        | <input type="checkbox"/> 5 # Health Records               |
| <input checked="" type="checkbox"/> Logbooks                          | <input type="checkbox"/> Key Control Log                             | <input type="checkbox"/> 5 # MH/SA Records                |
| <input checked="" type="checkbox"/> Continuity of Operation Plan      | <input checked="" type="checkbox"/> Fire Drill Log                   | <input type="checkbox"/> 7 # Personnel /Volunteer Records |
| <input checked="" type="checkbox"/> Contract Monitoring Reports       | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | <input type="checkbox"/> 8 # Training Records             |
| <input type="checkbox"/> Contract Scope of Services                   | <input checked="" type="checkbox"/> Precautionary Observation Logs   | <input type="checkbox"/> 8 # Youth Records (Closed)       |
| <input checked="" type="checkbox"/> Egress Plans                      | <input checked="" type="checkbox"/> Program Schedules                | <input type="checkbox"/> 2 # Youth Records (Open)         |
| <input checked="" type="checkbox"/> Fire Inspection Report            | <input checked="" type="checkbox"/> List of Supplemental Contracts   | <input type="checkbox"/> # Other: ___                     |
| <input checked="" type="checkbox"/> Exposure Control Plan             | <input checked="" type="checkbox"/> Vehicle Inspection Reports       | ___   |

**Observations During Review**

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

**Surveys**

- |                                       |   |                                     |                          |
|---------------------------------------|---|-------------------------------------|--------------------------|
| <input type="checkbox"/> 0 # of Youth | <input checked="" type="checkbox"/> 3 # of Direct Staff | <input type="checkbox"/> # of Other | <input type="checkbox"/> |
|---------------------------------------|---|-------------------------------------|--------------------------|

## 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**

The Florida Keys Children's Shelter is located at 73 High Point Road Tavernier, Florida 33070. The shelter serves youth in Monroe county. The Florida Keys Children's Shelter - Jelsema Center is a 19 bed home in Tavernier which is open 24 hours a day, seven days a week, 365 days a year, serving youth ages 10-17. Community Counseling programs consist of teams of qualified and licensed counselors providing free counseling to youth ages 6-17, and their families.

### **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

Indicator 1.3 Incident Reporting was rated Satisfactory

Indicator 1.4 Training Requirements was rated Satisfactory

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 Satisfactory

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 Satisfactory

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

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

Indicator 3.5 Adjudication Services: Case Staffing was rated Satisfactory

Indicator 3.6 Staffing and Youth Supervision was rated Not Applicable

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

**Domain 4:** There are five indicators for Domain 4.

Indicator 4.0 SNAP® Under 12 was rated Not Applicable

Indicator 4.1 SNAP® Fidelity Monitoring was rated Not Applicable

Indicator 4.2 SNAP® for Youth was rated Not Applicable

Indicator 4.3 SNAP® Youth Justice was rated Not Applicable

Indicator 4.5 SNAP® for Schools and Communities was rated Not Applicable

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

Indicator 5.0 Shelter Program Services was rated Satisfactory

Indicator 5.1 Shelter Environment was rated Satisfactory

Indicator 5.2 Shelter Search Policy was rated Satisfactory

Indicator 5.3 Logbook Requirements was rated Satisfactory

Indicator 5.4 Staffing Standards and Enhanced Supervision was rated Satisfactory

Indicator 5.5 Behavior Management Strategies was rated Satisfactory

Indicator 5.6 Program Orientation was rated Satisfactory

Indicator 5.7 Youth Room Assignment was rated Satisfactory

Indicator 5.8 Video Surveillance was rated Satisfactory

**Domain 6:** There are five indicators for Domain 6.

Indicator 6.0 Medication Management and Distribution was rated Satisfactory

Indicator 6.1 Naloxone Administration and Opioid Overdose Response was rated Satisfactory

Indicator 6.2 Suicide Prevention was rated Satisfactory

Indicator 6.3 Healthcare Admission Screening was rated Satisfactory

Indicator 6.4 Medical/Mental Health Alert Process was rated Satisfactory

CINS/FINS QUALITY IMPROVEMENT TOOL		
<b>Quality Improvement Indicators and Results:</b>		<b>Summary/Narrative Findings:</b>
<p>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.</p> <p>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.</p> <p>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>		
<b>Domain One – Background Screening and Compliance</b>		
<b>1.0 - Background Screening</b>		<b>Satisfactory</b>
Provider has a written policy and procedure that meets the requirement for Indicator 1.0		Yes
Provider has implemented a Suitability Assessment policy and procedure that meets the requirement for Indicator 1.0		Yes
		The agency has a policy 1.12 Background Screening and Post Hire Arrest approved by the CEO on 01/16/2026.   The program uses and interview suitability quiz consisting of 11 multiple choice questions with a scoring tool.
<b>A total of seven file(s) were reviewed during this evaluation period. Of these, six new hire file(s) and one 5-year rescreen file(s) were reviewed. The sample included seven employee(s) and zero volunteer(s).</b>		
<b>Suitability Assessment</b>		
All positions providing direct services (residential and community counseling) to youth has successfully passed pre-employment suitability assessment on the initial attempt.	<b>Compliance</b>	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.	<b>Not Applicable</b>	All applicants passed the suitability assessment on the initial attempt.
Did the applicant pass the suitability assessment?	<b>Compliance</b>	All applicant files confirmed a passing result for the suitability assessment.

Employees who have a break in service may be reemployed with the same agency without an additional suitability assessment if the break is less than eighteen (18) months. However, if the provider changed or updated the assessment tool used, there is evidence that the employee completed the new assessment.	<b>Not Applicable</b>	None of the applicants had a break in service.
<b>New Hire</b>		
For New Hires-The background screening was completed and the applicant was determined eligible prior to the date of hire.	<b>Compliance</b>	Background screenings for all new hires were completed, and eligibility was confirmed prior to each hire date.
For employee, contractor, volunteer, or intern who provide services for ten (10) or more hours per month-The background screening was completed and volunteer/mentor or intern determined eligible prior services being provided.	<b>Not Applicable</b>	All employee files reviewed had eligible background screenings prior to services being provided.
For those with ineligible background screenings, the exemption was obtained prior to working with youth.	<b>Not Applicable</b>	Nine new-hire employee files contained evidence of eligible background screenings prior to the date of hire.
<b>E-Verify</b>		
The file contains proof of E-Verify for all new employees obtained from the Department of Homeland Security.	<b>Compliance</b>	All personnel files contained valid E-Verify confirmations from the Department of Homeland Security verifying employment eligibility.
<b>5 Year Rescreening</b>		
Five year re-screening was completed prior to the 5-year anniversary date of initial hire or prior to expiration of retained fingerprints date.	<b>Compliance</b>	All five-year re-screenings were completed on or before the employee's five-year anniversary or fingerprint expiration date, whichever came first.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>1.1 - Annual Affidavit of Compliance with Good Moral Character Standards</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.1</b>		Yes
		The agency has a policy 1.12 Background Screening and Post Hire Arrest approved by the CEO on 01/16/2026.
Affidavit of Annual Compliance with Level 2 Screening Standard (Form IG/BSU-006) is completed and submitted to BSU by January 31st.	<b>Compliance</b>	The Affidavit of Annual Compliance with Level 2 Screening Standard (Form IG/BSU-006) was completed and submitted to BSU by the required deadline of January 31.

Affidavit of Annual Compliance with Level 2 Screening Standard was submitted sent to BSU by (at minimum): a. fax confirmation b. email confirmation	<b>Compliance</b>	Each affidavit submission included documented proof of delivery to BSU, verified through fax or email confirmation.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>1.2 - Provision of an Abuse Free Environment</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.2</b>		Yes
		The agency has a policy 1.07 Reporting of Child Abuse approved by the CEO on 01/16/2026.
The program has a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation, and there is evidence that it is provided to staff.	<b>Compliance</b>	The program maintains a formal code of conduct that strictly prohibits physical abuse, profanity, threats, intimidation, and other inappropriate behavior. The code of conduct is provided to all staff, with documented acknowledgment of receipt.
The Child Abuse Hotline number is clearly posted and visible for youth and staff to see.	<b>Compliance</b>	The Child Abuse Hotline number is clearly posted in visible locations accessible to both youth and staff.
The program has a process in place for reporting and documenting any child abuse hotline calls.	<b>Compliance</b>	The program has an established process for promptly reporting and documenting all child abuse hotline calls in accordance with state and agency policy. Staff are trained and compliant with reporting procedures.
The agency is an abuse free environment.	<b>Compliance</b>	Survey feedback confirms the agency maintains an abuse-free environment, with no reported concerns from completed surveys.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>1.3 - Incident Reporting</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.3</b>		Yes
		The program has a policy and procedure. The policy number is 1.13 Incident Reporting, which was last reviewed on 12-4-25 and updated and signed by the Chief Executive Officer on 1-16-2026.
<b>Data sources Reviewed</b>	<b>Dates Reviewed</b>	<b>Logbook Dates for Sample Size:</b>
CCC reports Incident reports Logbooks	CCC 12-19-25,7-12-25	8/17/2025 - 12/15/2025, 8/31/2025, 9/28/2025, 10/26/2025, 11/4/2025, 11/28/2025

The program notified the Department’s CCC and reportable incidents were consistently reported as required, no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident.	<b>Compliance</b>	The program consistently reported incidents to the CCC within the required two-hour timeframe.
The program completes follow-up communication tasks/special instructions as required by the CCC.	<b>Compliance</b>	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.	<b>Compliance</b>	Incidents and CCC calls were documented in the program logs and logbooks as required.
Agency internal incidents are documented on incident reporting forms or electronically and all CCC reportable incidents were consistently reported to CCC as required.	<b>Compliance</b>	Agency internal incidents are consistently documented using approved incident reporting forms or electronic systems, and all CCC-reportable incidents are reported to the CCC in accordance with established requirements.
All incident reports are reviewed and signed by program supervisors/directors.	<b>Compliance</b>	All incident reports were reviewed and signed by program supervisors or directors.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>1.4 - Training Requirements</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.4</b>		Yes
		The program has a policy and procedure. The policy number is 1.4 Staff Training and Professional Development which was last reviewed on 8-26-25 and updated/signed by the Chief executive officer on 1-16-26.
<b>A total of 0 first-year non-licensed Mental Health Clinical Shelter staff file(s) were reviewed. 4 new hire staff and 4 annual staff files were reviewed for compliance with training completed within the required timeframe(s).</b>		
<b>Policy &amp; New Hire Training</b>		
Trainings that are required by the Network and other funders must be documented in each individual staff member's file and on the FLN Training Log or similar document with the minimum requirements i.e. Staff Name & Position, Date of Hire, Training anniversary used by agency (calendar, date of hire or fiscal), Training Name, Training Hours, Cumulative Total, Training Completion or Facilitation Date, Location of Training or Platform Used (when virtual).	<b>Compliance</b>	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)	<b>Compliance</b>	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.

<b>Pre-Service Training</b>		
Agency policies and procedures	<b>Compliance</b>	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.	<b>Compliance</b>	Staff reviewed the Contraband Overview and Search Policy and signed the required acknowledgment form.
Behavior Management	<b>Compliance</b>	Behavior Management training was completed prior to independent work with youth.
Building/Facility layout	<b>Compliance</b>	Staff received orientation to the building and facility layout.
File Documentation/Paperwork Requirements	<b>Compliance</b>	File documentation and paperwork requirement training was completed as required.
Confidentiality (FYSB / DCF / Skill Pro)	<b>Compliance</b>	Confidentiality training (FYSB / DCF / SkillPro) was completed and documented in staff files.
CCC & Incident Reporting	<b>Compliance</b>	Staff completed CCC and Incident Reporting training prior to working independently.
Child Abuse Reporting	<b>Compliance</b>	Child Abuse Reporting training was completed and verified in the staff record.
Client Intake & Screening	<b>Compliance</b>	Client Intake and Screening training was completed prior to independent case assignment.
Client Orientation (Shelter only)	<b>Compliance</b>	Staff completed Client Orientation training on delivering new client orientations.
Fire Safety Equipment (In-person by a supervisor or other program trainer)	<b>Compliance</b>	Fire Safety Equipment training was completed in person by a supervisor or program trainer.
Fire Safety Equipment (Skill Pro #215 or DCF)	<b>Compliance</b>	Fire Safety Equipment (SkillPro #215 or DCF) training completion is documented.
Medical and Mental Health Alert System	<b>Compliance</b>	Medical and Mental Health Alert System training was completed as required.
Disaster Preparedness	<b>Compliance</b>	Disaster Preparedness training was completed and verified in training logs.
Universal Precautions / Communicable Diseases / Infection Control / Bloodborne Pathogens Part I & II	<b>Compliance</b>	Universal Precautions, Communicable Diseases, Infection Control, and Bloodborne Pathogens Parts I & II training were completed and documented.

CPR/First Aid (By CPR Certified Instructor)	<b>Compliance</b>	CPR/First Aid training was completed by a certified instructor prior to independent duty.
Video Camera Surveillance & Equipment	<b>Compliance</b>	Staff completed Video Camera Surveillance and Equipment training prior to shift assignment.
CINS/FINS Core	<b>Compliance</b>	CINS/FINS Core training was completed and verified.
Crisis Intervention [e.g., MAB (2-day/16 hours)]	<b>Compliance</b>	Crisis Intervention training (e.g., MAB or FN-approved equivalent) was completed and documented.
Florida Network Youth Suicide Prevention	<b>Compliance</b>	Florida Network Youth Suicide Prevention training was completed within the required timeframe.
Adolescent Development / Positive Youth Development	<b>Compliance</b>	Adolescent Development and Positive Youth Development training were completed and recorded.
Cultural Humility/Diversity	<b>Compliance</b>	Cultural Humility and Diversity training was completed through an approved provider (Bridge or RHYTTAC).
Mental Health and Substance Abuse	<b>Compliance</b>	Mental Health and Substance Abuse training was completed and documented in the staff record.
<b>Skill Pro Required Trainings:</b>		
Child Abuse: Recognition, Reporting and Prevention	<b>Compliance</b>	Staff completed Child Abuse: Recognition, Reporting, and Prevention training within the first 90 days of employment or service.
Equal Employment Opportunity	<b>Compliance</b>	Equal Employment Opportunity training was completed and documented within the first 90 days.
Human Trafficking Intervention for Direct Care Staff	<b>Compliance</b>	Human Trafficking Intervention for Direct Care Staff training was completed as required.
Information Security Awareness	<b>Compliance</b>	Information Security Awareness training was completed within the required timeframe.
Prison Rape Elimination Act (PREA) - Part 1	<b>Compliance</b>	Prison Rape Elimination Act (PREA) – Part 1 training was completed and documented in staff records.
Prison Rape Elimination Act (PREA) - Part 2	<b>Compliance</b>	Prison Rape Elimination Act (PREA) – Part 2 training was completed and verified in the staff file.
Sexual Harassment	<b>Compliance</b>	Sexual Harassment training was completed within the first 90 days of employment or service.
Trauma Responsive Practices	<b>Compliance</b>	Trauma Responsive Practices training was completed and documented as required.
<b>Additional FL Network Required Trainings:</b>		

Naloxone Training	<b>Compliance</b>	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)	<b>Compliance</b>	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 )	<b>Not Applicable</b>	Four staff file were reviewed and none were applicable for this training base on specific job functions.
<b>STAFF SPECIFIC TRAINING - Florida Network and SkillPro Required Trainings Related to Specific Staff Roles</b>		
JJIS (Juvenile Justice Information System) System Access (Required for staff who enter and monitor SVS prior to accessing JJIS)	<b>Compliance</b>	Staff requiring JJIS access completed Juvenile Justice Information System (JJIS) System Access training prior to entry or monitoring.
JJIS Alerts – Part 1 (JJIS Data Entry Staff prior to accessing JJIS)	<b>Compliance</b>	JJIS Data Entry staff completed JJIS Alerts – Part 1 training before accessing JJIS.
JJIS Alerts – Part 2 (JJIS Data Entry Staff prior to accessing JJIS)	<b>Compliance</b>	JJIS Data Entry staff completed JJIS Alerts – Part 2 training before accessing JJIS.
Motivational Interviewing (MI) (Prior to NIRVANA training for Staff who Administer the NIRVANA)	<b>Compliance</b>	Staff responsible for administering the NIRVANA® completed Motivational Interviewing (MI) training prior to NIRVANA® instruction.
NIRVANA Assessment (Required for all staff who Administer the NIRVANA, prior to administering the NIRVANA)	<b>Not Applicable</b>	Four staff files were reviewed and non were applicable for NIRVANA Assessment due to job description.
Medication Distribution for Shelter Staff Without a Medical License (Prior to administration of medication and annually)	<b>Compliance</b>	Shelter staff without a medical license completed Medication Distribution training prior to administering medication and renewed annually.
PYXIS (Authorized Shelter Staff prior to accessing Pyxis system)	<b>Compliance</b>	Authorized shelter staff completed PYXIS training prior to accessing the Pyxis system.
SNAP Support Overview *This training does not certify staff to facilitate SNAP After completing training, this Supporter must only be paired with a fully trained SNAP Facilitator	<b>Not Applicable</b>	The program does not participate in SNAP.
SNAP Facilitator Training (Required for All Staff prior to the delivery of Groups)	<b>Not Applicable</b>	The program does not participate in SNAP.
NetMIS Training (For NetMIS Users prior to accessing NetMIS)	<b>Not Applicable</b>	Four staff files were reviewed and none were applicable based on job description.

<p>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)</p>	<p><b>Not Applicable</b></p>	<p>Four staff files were reviewed for training and none were applicable base on job description.</p>
<p>NON-LICENSED CLINICAL STAFF ONLY 16 hours clinical training + 36 hours topic-specific training (Covering: basic counseling skills, basic group therapy skills, treatment model and program philosophy, therapeutic milieu, behavior management, client rights, crisis intervention, early intervention and de-escalation, documentation requirements, normal and abnormal adolescent development, typical behavior problems) * Prior to working with youth*</p>	<p><b>Not Applicable</b></p>	<p>Four staff files were reviewed for training and none were applicable based on job description.</p>
<p>NON-LICENSED CLINICAL STAFF ONLY Mental health and substance-related disorders; Counseling theory and techniques; Group dynamics and therapy; Treatment and discharge planning. (Required for Bachelor's level non-licensed counseling staff without 2 years clinical experience assessing, counseling or treating youth with serious emotional disturbance or substance abuse problems) *To be completed during first year of employment*</p>	<p><b>Not Applicable</b></p>	<p>Four staff files were reviewed for training and none were applicable based on job description.</p>
<p>For any trainings that are NOT completed within the required timeframe, includes documentation of the reason and scheduled completion date.</p>	<p><b>Not Applicable</b></p>	<p>Four files reviewed and each files had all required training documents.</p>
<p>Direct Care staff (full-time, part-time, and on-call) complete all pre-service requirements prior to working independently and achieve a minimum of 80 hours of training during their first year.</p>	<p><b>Compliance</b></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>

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.	<b>Not Applicable</b>	Each staff file reviewed confirmed there was no break in service.
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.	<b>Not Applicable</b>	Four staff files were reviewed, and all training were complete by a qualified trainer.
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.	<b>Compliance</b>	The agency has a designated staff member responsible for managing all employee training files and routinely reviews them to ensure compliance.
All Network-required training is supported by documentation such as certificates, sign-in sheets, and agendas.	<b>Compliance</b>	All Network-required trainings are supported by appropriate documentation, including certificates, sign-in sheets, and training agendas.
<b>Annual Training</b>		
Trainings that are required by the Network must be documented in each individual training file or employee file as well as captured on the FLN Training Log or similar document with the minimum requirements (i.e. Staff Name & Position, Date of Hire, Training anniversary used by agency (calendar, date of hire or fiscal), Training Name, Training Hours, Training Completion or Facilitation Date, Location of Training or Platform Used (when virtual), and Cumulative Total Training Hours )	<b>Compliance</b>	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)	<b>Compliance</b>	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)	<b>Compliance</b>	Human Trafficking Intervention for Direct-Care Staff training is completed annually and supported by required documentation.
Information Security Awareness (Annually)	<b>Compliance</b>	Information Security Awareness training is completed annually and verified through certificates or attendance records.
Prison Rape Elimination Act (PREA) Part 1 (Every 2 years)	<b>Compliance</b>	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)	<b>Compliance</b>	Prison Rape Elimination Act (PREA) Part 2 training is completed every two years and supported by appropriate documentation.
Sexual Harassment (Every 2 Years)	<b>Compliance</b>	Sexual Harassment training is completed every two years and verified in staff files.

Trauma Responsive Practices (Every 2 Years)	<b>Compliance</b>	Trauma Responsive Practices training is completed every two years and documented on the FLN Training Log and in staff training files.
<b>FL Network Annual Required Trainings REQUIRED for Staff Over 1 year</b>		
Florida Network Youth Suicide Prevention (Required Annually)	<b>Compliance</b>	Florida Network Youth Suicide Prevention training is completed annually and documented in staff training files.
CPR (Every 2 Years - Check for current validity)	<b>Compliance</b>	CPR certification is current and renewed every two years in accordance with <u>Network requirements</u> .
First Aid (Every 2 Years - Check for current validity)	<b>Compliance</b>	First Aid certification is current and renewed every two years, with <u>documentation maintained in the staff file</u> .
Crisis Intervention training approved by the Network (ex: Managing Aggressive Behavior (MAB) (Every 2 Years)	<b>Compliance</b>	Crisis Intervention training (e.g., Managing Aggressive Behavior – MAB) is completed every two years as approved by the Network.
In-Person Fire Safety Equipment (Every 2 years)	<b>Compliance</b>	In-person Fire Safety Equipment training is completed every two years and properly documented.
Virtual Fire Safety Equipment (Every 2 years)	<b>Compliance</b>	Virtual Fire Safety Equipment training is completed every two years and properly documented.
Medication Distribution for Staff Without a Medical License (Re-certification annually)	<b>Compliance</b>	Medication Distribution training for staff without a medical license is re-certified annually and verified through documentation.
SNAP Refresher Training (Annually for all staff who have completed SNAP Facilitator Training and are delivering SNAP group services or monitoring fidelity)	<b>Not Applicable</b>	None of the training files reviewed were SNAP staff.
For missed trainings, documentation includes the reason for delay and scheduled completion timeline.	<b>Not Applicable</b>	Four files reviewed and each file had all required documents.
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.	<b>Compliance</b>	All direct-care Community Counseling staff meet the annual minimum requirement of 24 total training hours.
All direct care Shelter Staff meet the annual requirement of a minimum of 40 hours for residential programs licensed by DCF of the total hours of training received for the year. *This includes residential counselor or other direct care staff positions working with youth in shelter.*	<b>Compliance</b>	All direct-care Shelter staff meet the annual minimum requirement of 40 total training hours, as required for residential programs licensed by DCF.
Annual and Biannual training must be due on a calendar or fiscal year basis, not based on hire date.	<b>Compliance</b>	Annual and biannual training schedules are tracked and completed based on the agency's established calendar or fiscal year cycle, not hire date.
All Network-required training is supported by documentation such as certificates, sign-in sheets, and agendas.	<b>Compliance</b>	All Network-required trainings are supported by documentation such as certificates, sign-in sheets, and training agendas.
<b>Additional Comments: There are no additional comments for this indicator.</b>		

<b>1.5 - Data Entry &amp; Collection</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.5</b>		Yes
		The agency has a policy # 1.19 Data Entry & Collection and Analysis and Reporting reviewed by the CEO on 1/16/2026.
The program has a quality improvement process in place that includes designated staff responsibilities to ensure data accuracy and quality.	<b>Compliance</b>	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.	<b>Compliance</b>	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 (via meeting minutes/agendas). This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, and follow-up reporting measures.	<b>Compliance</b>	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
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>1.6 - Risk Management/ Analyzing and Reporting Information</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.6</b>		Yes
		The agency has a policy # 1.20 Risk Management - Internal Quality Monitoring reviewed by the CEO & COO on 1/16/2026.
<b>Data sources Reviewed</b>		<b>Dates Reviewed</b>
FKCS Board Meeting Minutes, Meeting Minutes for Staff & Programmatic Meetings, EOM Report (FL Network), Risk Prevention & Management Quarterly Reports, Performance and Quality Improvement Annual Plan/Report		10/30/2025, August 2025 thru Jan 2026, August 2025 thru Jan 2026, July 2025 to December 2025, Covers January 2025 thru December 2025
The program provides reports of aggregated data and committee/workgroup minutes analyzing information.	<b>Compliance</b>	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.)	<b>Compliance</b>	Quarterly case record reviews are conducted as required, with summary reports identifying compliance with CINS/FINS standards. Results are reviewed by management and communicated to staff on a quarterly basis.
The program reviews incidents, accidents, and grievances at least quarterly.	<b>Compliance</b>	The program conducts regular reviews of all incidents, accidents, and grievances at least quarterly, ensuring timely analysis, corrective actions, and preventive
The program reviews customer satisfaction data at least annually.	<b>Compliance</b>	Customer satisfaction data is reviewed annually, and feedback is used to enhance service quality and client experience.
The program reviews outcome data at least annually.	<b>Compliance</b>	Program outcome data is reviewed annually to assess performance against goals and inform quality improvement efforts.
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	<b>Compliance</b>	Findings from reviews are consistently evaluated by management and effectively communicated to staff and stakeholders to ensure transparency and alignment.
The program demonstrates program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the provider's Executive Committee on the Board of Directors.	<b>Compliance</b>	Program performance is routinely presented to the Board of Directors. All final reports receiving a Limited or Failed rating are submitted to the Executive Committee electronically or by mail, as required.
Evidence shows that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	<b>Compliance</b>	Documentation reflects that program strengths and weaknesses are identified, corrective actions implemented, and staff are informed and engaged throughout the improvement process.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>1.7 - Client Transportation</b>	<b>Satisfactory</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.7</b>	Yes	
	The agency has a policy # 8.02 Transportation of Youth reviewed by the CEO & COO on 1/16/26.	
Supervisors complete a weekly review of transport documentation and provide written feedback or coaching when deficiencies are found.	<b>Compliance</b>	Supervisors complete weekly reviews of all transport documentation and provide written feedback or coaching whenever deficiencies are identified.
The agency has a practice, review, and approval process in place regarding the transportation of youth assigned to the program.	<b>Compliance</b>	The agency maintains an established transportation policy and formal approval process that governs all youth transports, ensuring safety and accountability.

All drivers have an approved driver’s license.	<b>Compliance</b>	All approved drivers hold valid driver’s licenses verified by the agency prior to transporting youth.
List of approved drivers eligible to drive client(s) for the agency or approved private vehicle that considers the driver’s work performance and history, indicating no inappropriate behavior is likely to occur.	<b>Compliance</b>	The agency maintains a current list of approved drivers eligible to transport clients, confirming each driver’s satisfactory work performance and history free from inappropriate behavior.
The list of approved drivers are covered under the agency's automobile insurance.	<b>Compliance</b>	All approved drivers are covered under the agency’s automobile insurance policy, and verification of coverage is maintained on file.
There is documentation of use of a vehicle that notes the name or initials of the driver, date and time, mileage, number of passengers, purpose of travel, and location.	<b>Compliance</b>	Vehicle logs consistently record the driver’s name or initials, date, time, mileage, number of passengers, travel purpose, and destination, providing complete accountability for all transports.
Signed parental consent is obtained in advance of any single transport.	<b>Compliance</b>	All youth records for applicable single youth transports contained signed parental consent in advance of any single transport.
If a single staff is transporting youth in a vehicle, there is evidence that the Program Director approved it (prior to the transport) and the approval is documented accordingly prior to the client transport.	<b>Compliance</b>	Evidence shows that program directors reviewed and approved all single-staff transports prior to travel, and approvals were properly documented.
If there is no signed parental consent for single staff transport and the transport is necessary and cannot be delayed; in addition to the single staff transportation requirements above, there is evidence that the transporting employee completed a check-in by phone at agreed-upon intervals with the senior program leader or designee, upon departure and arrival. The employee check-ins must be documented by the manager or designee receiving the call.	<b>Compliance</b>	All single-staff transports included required phone check-ins with a senior program leader or designee upon departure and arrival, with each check-in documented by the receiving manager.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>1.8 - Client Contact Policy</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.8</b>		Yes
		The agency has a policy 1.27 Client Contact Policy approved by the CEO 01/16/2026.
<b>Additional Comments: There are no additional comments for this indicator.</b>		

<b>1.9 - Community Referrals and Outreach Services</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.9</b>		Yes
		The agency has a policy 1.9 Community Referrals and Outreach Services approved by the CEO on 01/16/2026.
<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>	<b>Compliance</b>	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.
The program has evidence that provides minutes of the event or other verification of staff participation.	<b>Compliance</b>	Documentation such as meeting minutes, sign-in sheets, and event summaries confirm active staff participation in all outreach activities.
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.	<b>Compliance</b>	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.
This responsibility is specified in their job description.	<b>Compliance</b>	The outreach lead’s job description clearly defines responsibility for community engagement, DJJ participation, and oversight of outreach activities.
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.	<b>Compliance</b>	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.

Outreach activities include education about services offered and guidance on accessing those services. The program has evidence that provides minutes of the event or other verification of staff participation.	<b>Compliance</b>	Outreach efforts include a variety of engagement methods such as group presentations, individual meetings, short-term intervention groups, informational displays at community events, facility tours, and media participation. These activities demonstrate strong community visibility and connection.
The program maintains written agreements with other community partners, which include services provided and a comprehensive referral process.	<b>Compliance</b>	The program maintains current written agreements with community partners outlining provided services and a clearly defined referral process that supports coordinated care.
Copies of agreements are forwarded to the Florida Network.	<b>Compliance</b>	Copies of all partnership agreements are submitted to the Florida Network as required, ensuring transparency and statewide coordination of services.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>Domain Three</b>		
<b>3.2 - Admission Process</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.2</b>	Yes	
	The agency has a policy 3.2 Admission Process which was reviewed and approved on 1/16/26 by the CEO and COO.	
<b>A total of ten file(s) were reviewed during this evaluation period. Of these, two were open and eight were closed. Among the open file(s), zero residential (RES) and two community counseling file(s) were reviewed. Among the closed file(s), five residential (RES) and three community counseling file(s) were reviewed.</b>		
The screening form is completed immediately for all inquiries into shelter placement.	<b>Compliance</b>	For all inquiries into shelter placement, screening forms were completed immediately by trained staff, ensuring timely assessment and appropriate service placement.
<u>For Community Counseling Services:</u> The initial screening for eligibility for Community Counseling Services (including screening for eligibility, crisis counseling and information, and referral) occurs within 3 business days of referral by a trained staff member using, at minimum, the Florida Network screening form.	<b>Compliance</b>	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.
<b>Youth and parents/guardians receive the following in writing</b>		

Youth and parents/guardians are provided available service options in writing.	<b>Compliance</b>	Youth and parents/guardians were provided written information outlining all available service options, ensuring informed decision-making about participation.
Youth and parents/guardians are provided "Rights and Responsibilities of Youth" in writing.	<b>Compliance</b>	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.	<b>Compliance</b>	Parents and guardians were provided the "Rights and Responsibilities of Parents" brochure at intake, and signed acknowledgment forms were present in all records.
<b>The following is also available to the youth and parents/guardians:</b>		
Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication).	<b>Compliance</b>	Youth and parents/guardians received written information describing possible outcomes and actions that may occur through involvement with CINS/FINS services, including case staffing, petitions, and adjudications.
Youth and parents/guardians are provided information regarding the programs grievance procedures.	<b>Compliance</b>	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.	<b>Not Applicable</b>	All ten files reviewed participated in services.
The intake took place in a setting that allows the client to feel safe and heard.	<b>Compliance</b>	Intakes were conducted in private, trauma-informed settings designed to help youth feel safe, respected, and heard throughout the process.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>3.3 - NIRVANA (Network Inventory of Risks, Victories, and Needs Assessment)</b>		<b>Satisfactory with Exception(s)</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.3</b>		Yes
		The agency has a policy 3.3 Nirvana reviewed and approved on 1/16/26 by the CEO and the COO.

For youth in shelter care: NIRVANA Assessment initiated within 72 hours of admission.	<b>Compliance</b>	All youth admitted to shelter care had their NIRVANA Assessment initiated within 72 hours of admission, ensuring prompt evaluation and service engagement.
For youth in shelter care: NIRVANA Assessment is completed within seven (7) days from intake.	<b>Compliance</b>	All NIRVANA Assessments for shelter youth were completed within seven days of intake, confirming timely completion of assessment requirements.
NIRVANA Assessment is completed within one to two contacts following the initial intake date into services.	<b>Compliance</b>	All Community Counseling NIRVANA Assessments were completed within one to two contacts after intake, consistent with Florida Network guidelines.
NIRVANA Assessment is initiated at intake.	<b>Compliance</b>	All components of the NIRVANA process initiation were fully compliant and supported by documentation in each file.
NIRVANA Assessment was conducted by a bachelor's or master's degree staff who has completed the Florida Network NIRVANA training and has had Motivational Interviewing (MI).	<b>Compliance</b>	All assessments were completed by qualified bachelor's or master's level staff who successfully completed both NIRVANA and Motivational Interviewing training, verified through the staff roster.
All completed NIRVANA assessments are entered electronically into the Florida Network Management Information System (NetMIS) within three (3) business days of service commencement.	<b>Exception</b>	The NIRVANA for one of ten youth files reviewed was completed on 10/7/25 but was not entered into the NetMIS system until 10/23/25. It was 13 days late. The NIRVANA should have been entered within three business days of service commencement.
The supervisor's signature is documented on the completed NIRVANA Assessment and/or the chronological note and/or the interview guide that is located in the youths' file within 7 business days.	<b>Exception</b>	The supervisor signed the NIRVANA Assessment for one youth on 10/23/25, which was after the deadline. According to the policy, the supervisor should have signed it within seven days of its completion date on 10/7/25.
(Shelter only) NIRVANA Self-Assessment Report (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	<b>Compliance</b>	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.	<b>Compliance</b>	All youth with stays exceeding 30 days received a completed NIRVANA Post-Assessment at discharge to measure progress and outcomes.

A NIRVANA Re-Assessment is completed every 90 days with the exception of SNAP services.	<b>Not Applicable</b>	None of the ten files reviewed required a NIRVANA Re-Assessment.
All files must have the interview guide and/or printed NIRVANA.	<b>Compliance</b>	Each file reviewed contained a completed interview guide and/or a printed copy of the NIRVANA Assessment, demonstrating proper documentation and retention.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>3.4 - Case Management, Counseling &amp; Non-Residential Services Policy</b>		<b>Satisfactory with Exception(s)</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.4</b>	Yes	
	The agency has a policy 3.7 Service Plan which was reviewed and approved on 1/16/26 by the CEO and the COO.	
Each client is assigned a Counselor.	<b>Compliance</b>	Each client was assigned a qualified counselor responsible for coordinating services and maintaining consistent therapeutic engagement.
<b>The following is also available to the youth and parents/guardians:</b>		
In the Shelter Program: Counseling services are provided to each client at least once per week, for the first 12 weeks of services, by a licensed mental health professional or non-licensed staff with clinical experience or has completed the required clinical training working under the direct supervision of a licensed staff member.	<b>Compliance</b>	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.
Community Counseling Program: Counseling services are provided to each client at least once per week, for the first 12 weeks of services, by a licensed mental health professional or nonlicensed staff working under the direct supervision of a licensed staff. <i>(May include Individual, group, and family counseling, Crisis intervention, Parent training, Community-based mental health and substance abuse referrals, Case management, Prevention and diversion services, Skills training, tutorial/remedial services, Vocational, job training, or employment services, and Recreational services)</i>	<b>Exception</b>	Counseling services are held weekly, but one session for two of ten clients reviewed was missing.
The reason(s) why a required weekly session could not be provided is documented in the youth's file and in NetMIS.	<b>Exception</b>	Two youth case files did not contain a documented reason for missing sessions.

If case management needs extend beyond the counselor's role, a case manager is assigned.	<b>Not Applicable</b>	Counseling staff handles all case management needs of the youth.
Case Manager establishes appropriate referrals to services.	<b>Not Applicable</b>	Counseling staff handles all case management needs of the youth.
All counseling and case management sessions are documented in the youth's file and NetMIS, including the reason for missed sessions.	<b>Exception</b>	The reason for missing counseling sessions, for two youth, were not documented in NetMIS.
If mental health or substance abuse needs, outside of the program's capacity, are identified appropriate referrals are made and documented.	<b>Compliance</b>	When mental health or substance abuse issues outside program capacity were identified, appropriate referrals were made to external providers and fully documented.
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.	<b>Not Applicable</b>	None of the ten youth files reviewed were receiving respite services.
Clients that do not receive services for 30 days or more have their case closed.	<b>Compliance</b>	Cases were closed for clients who had not received services for 30 days or more, in compliance with program standards.
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.	<b>Compliance</b>	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.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>3.5 - Adjudication Services: Case Staffing</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.5</b>		Yes
		The program has a policy 3.5 Adjudication Services/Case Staffing which was reviewed and approved on 1/16/26 by the CEO and the COO.

<p><b>A total of zero file(s) were reviewed during this evaluation period. Of these, zero were open and zero were closed. Among the open file(s), zero residential (RES) and zero community counseling file(s) were reviewed. Among the closed file(s), zero residential (RES) and zero community counseling file(s) were reviewed.</b></p>		
<p>A case staffing committee meeting is scheduled when one of the following occur (at minimum):</p> <ol style="list-style-type: none"> <li>1. the youth/family is not in agreement with services or treatment;</li> <li>2. the youth/family will not participate in the services selected,</li> <li>3. the youth's referring problem has not shown substantial improvement within six weeks of initiating counseling.</li> <li>4. the program receives a written request from the parent/guardian or any other member of the committee</li> </ol>	<p><b>Not Applicable</b></p>	<p>The program had no case staffing cases back to the date of the last review.</p>
<p>Each case staffing must be recorded in NetMIS within the case, noting the date it occurred.</p>	<p><b>Not Applicable</b></p>	<p>The program had no case staffing cases back to the date of the last review.</p>
<p>The case staffing is convened within 7 days (excluding weekends and legal holidays) of the parent/guardian request.</p>	<p><b>Not Applicable</b></p>	<p>The program had no case staffing cases back to the date of the last review.</p>
<p>Notification to the family is sent no less than 5 working days prior to staffing.</p>	<p><b>Not Applicable</b></p>	<p>The program had no case staffing cases back to the date of the last review.</p>
<p>Notification to the committee is sent no less than 5 working days prior to the staffing date.</p>	<p><b>Not Applicable</b></p>	<p>The program had no case staffing cases back to the date of the last review.</p>
<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.</p>	<p><b>Not Applicable</b></p>	<p>The program had no case staffing cases back to the date of the last review.</p>
<p>As a result of the case staffing committee meeting, the youth and family are provided a new or revised plan for services.</p>	<p><b>Not Applicable</b></p>	<p>The program had no case staffing cases back to the date of the last review.</p>
<p><b>At a minimum, the case staffing is attended by:</b></p>		
<p>Local school district representative</p>	<p><b>Not Applicable</b></p>	<p>The program had no case staffing cases back to the date of the last review.</p>
<p>DJJ rep. or CINS/FINS provider</p>	<p><b>Not Applicable</b></p>	<p>The program had no case staffing cases back to the date of the last review.</p>
<p><b>Other members may include:</b></p>		

State Attorney's Office	Not Applicable	The program had no case staffing cases back to the date of the last review.
Mental health representative	Not Applicable	The program had no case staffing cases back to the date of the last review.
Substance abuse representative	Not Applicable	The program had no case staffing cases back to the date of the last review.
Law enforcement representative	Not Applicable	The program had no case staffing cases back to the date of the last review.
DCF representative	Not Applicable	The program had no case staffing cases back to the date of the last review.
Others requested by youth/family	Not Applicable	The program had no case staffing cases back to the date of the last review.
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.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>3.6 - Adjudication Services: CINS Petition Process</b>		<b>Not Applicable</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.6</b>		Yes
		The agency has a policy 3.6 Adjudication Services: CINS Petition Process which was reviewed and approved on 1/16/26 by the CEO and 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 had no case staffing cases back to the date of the last review.
The Case Manager/Counselor completes a review summary prior to the court hearing for a youth.	Not Applicable	The program had no case staffing cases back to the date of the last review.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>3.7 - Service Plan</b>		<b>Satisfactory with Exception(s)</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.7</b>		Yes
		The agency has a policy 3.7 Service Plan which was reviewed and approved on 1/16/26 by the CEO and 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.	<b>Compliance</b>	The Case/Service Plan is completed using approved provider forms or NETMIS, based on information from screening, intake, and NIRVANA.
<b>Youth and parents/guardians receive the following in writing</b>		
The Case/Service Plan reflects the individualized and prioritized needs and goals identified during the assessment process, including relevant domains from the NIRVANA.	<b>Compliance</b>	Individualized and prioritized needs and goals are clearly identified based on the assessment process, incorporating all relevant domains from the NIRVANA.
Each plan clearly documents the type of service(s) to be provided, the frequency, and the location of services.	<b>Compliance</b>	Each plan clearly outlines the type, frequency, and location of services to ensure structured and consistent service delivery.
The plan identifies the person(s) responsible for implementing each service or action step.	<b>Compliance</b>	The plan specifies the person(s) responsible for implementing each service or action step, promoting accountability and effective follow-through.
The target date(s) for completion are documented in the service plan for each identified goal.	<b>Compliance</b>	Each plan includes clear target date(s) for goal completion, supporting timely progress monitoring and accountability.
The actual completion date(s) are documented in the service plan for each identified goal.	<b>Compliance</b>	Actual completion date(s) are consistently recorded, demonstrating effective tracking of service delivery and goal attainment.
The signature of the youth is documented in the service plan.	<b>Compliance</b>	Youth signatures are present on plans, confirming their participation and agreement with the identified goals and services.
The signature of the parent/guardian is documented in the service plan.	<b>Compliance</b>	Parent/guardian signatures are obtained, reflecting engagement and shared responsibility in the service planning process.
If unavailable, the absence is documented with a reason on the plan.	<b>Not Applicable</b>	All signatures were present on each case/service plan reviewed.
The signature of the counselor is documented in the service plan.	<b>Compliance</b>	Counselor signatures are included on all plans, verifying professional oversight and approval of service goals and actions.
The signature of the LMHP reviewing the plan is signed within seven (7) days of plan completion.	<b>Compliance</b>	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.	<b>Compliance</b>	The date of plan initiation is clearly documented, ensuring clarity on when services and interventions began.
<b>The Case/Service Plan is formally reviewed and revised in collaboration with the youth and parent(s)/guardian(s):</b>		
At, 30 Days, following plan initiation.	<b>Exception</b>	One of seven applicable files showed a 30 day case/service plan review completed late on 1/16/26. It was 8 days late.
At, 60 Days, following plan initiation.	<b>Not Applicable</b>	None of the files reviewed were applicable for 60-day case/service plan reviews.
At, 90 Days, following plan initiation.	<b>Not Applicable</b>	None of the files reviewed were applicable for 90-day case/service plan reviews.
For court ordered youth, every six (6) months thereafter, or more frequently as needed to reflect changes in progress, needs, or service delivery.	<b>Not Applicable</b>	None of the cases reviewed were court ordered youth.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>3.8 - Youth Records</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.8</b>		Yes
		The agency has a policy 3.8 Youth Records which was reviewed and approved on 1/16/26 by the CEO and COO.
All records are marked "confidential".	<b>Compliance</b>	All youth records were clearly marked "Confidential," ensuring proper identification and adherence to privacy requirements.
All records are kept in a secure room or locked in a file cabinet that is marked "confidential" and only accessible by staff.	<b>Compliance</b>	All records were stored securely in locked file cabinets or designated confidential rooms accessible only to authorized staff.
When in transport, all records are locked in an opaque container marked "confidential".	<b>Compliance</b>	When transported, all records were placed in locked, opaque containers marked "Confidential," maintaining privacy and data security.
All records are maintained in a neat and orderly manner.	<b>Compliance</b>	Records were consistently maintained in a neat, orderly, and professional manner, ensuring quick access and review readiness.

<p>SHELTER FILES</p> <ol style="list-style-type: none"> <li>1. Table of Contents that outlines documents in each section</li> <li>2. Screening</li> <li>3. Informed Consent</li> <li>4. Photograph of the youth</li> <li>5. Shelter Intake Form</li> <li>6. Suicide Assessment (if needed)</li> <li>7. NIRVANA Self Report (NSR)</li> <li>8. NIRVANA full Assessment</li> <li>9. Plan of Service</li> <li>10. Chronological Notes</li> <li>11. Medication Inventory Form</li> <li>12. Approved contact list</li> <li>13. Copies of referrals made (if needed)</li> <li>14. Discharge summary once case is closed</li> </ol>	<p><b>Compliance</b></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"> <li>1. Table of Contents that outlines documents in each section</li> <li>2. Screening</li> <li>3. Informed Consent</li> <li>4. Community Counseling Intake Form</li> <li>5. Suicide Assessment (if needed)</li> <li>6. NIRVANA full Assessment</li> <li>7. Plan of Service</li> <li>8. Chronological case notes</li> <li>9. Copies of referrals made (if needed)</li> <li>10. Discharge summary once the case is closed</li> </ol>	<p><b>Compliance</b></p>	<p>Each Community Counseling file included all required documents, including a table of contents, screening forms, informed consent, intake documentation, NIRVANA assessment, Plan of Service, chronological notes, referrals, and discharge summary.</p>
<p>If records are kept electronically, the records are maintained securely and can be made immediately available upon request for audit purposes.</p>	<p><b>Not Applicable</b></p>	<p>The program does not keep records electronically.</p>
<p>Records are retained for five years after the termination date of the contract that is funding the youth's service.</p>	<p><b>Compliance</b></p>	<p>Records were retained in compliance with policy for a minimum of five years following the termination date of the contract funding the youth's services.</p>
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>		

<b>3.10 - Discharge and Follow Up</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.10</b>		Yes The program has a policy 3.10 Discharge and Follow Up which was reviewed and approved on 1/16/26 by the CEO and the COO.
30 day follow-ups are provided post discharge for all youth served.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	Discharge summaries clearly described the reason for termination, confirming appropriate closure of services and alignment with client progress.
Each file contains a discharge summary that outlines the events of the case, services provided, progress of the youth and family, and recommendations for future treatment or services.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	Each file contained a completed NIRVANA Post-Assessment, documenting the youth's progress and outcomes at discharge.

<p>For cases that are referred for services by Truancy Court for FINS services, or to the case staffing committee for consideration of a CINS petition as a result of truancy related issues; youth having been deemed Truant by the Court, the Provider shall verify school attendance during 30- and 60-day follow-ups if the youth remains subject to compulsory education. If verification cannot be obtained, efforts are documented in the youth's file.</p>	<p><b>Compliance</b></p>	<p>For cases referred due to truancy, school attendance was verified during the 30- and 60-day follow-ups for youth subject to compulsory education. When verification could not be obtained, all efforts were documented in the youth's file.</p>
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>		
<p><b>Domain Five</b></p>		
<p><b>5.0 - Shelter Program Services</b></p>		<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 5.0</b></p>		<p>Yes</p>
		<p>The program has a written policy #3.09 Shelter Program services and Environment and was reviewed/approved by CEO on 1/16/2026.</p>
<p>Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal.</p>	<p><b>Compliance</b></p>	<p>Youth are engaged in meaningful, structured activities seven days a week during awake hours, minimizing idle time and promoting positive development.</p>
<p>At minimum one hour of physical activity is provided daily.</p>	<p><b>Compliance</b></p>	<p>A minimum of one hour of physical activity is provided to youth each day as part of the daily schedule.</p>
<p>Youth are provided the opportunity to participate in a variety of faith-based activities aligned with their preference or spiritual beliefs. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities.</p>	<p><b>Compliance</b></p>	<p>Youth are offered opportunities to participate in faith-based activities aligned with their personal beliefs, and non-punitive structured activities are provided for those who choose not to participate.</p>
<p>Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read.</p>	<p><b>Compliance</b></p>	<p>Daily programming includes scheduled time for homework completion, access to age-appropriate reading materials, and opportunities for quiet reading and learning.</p>
<p>Daily programming schedule is publicly posted and accessible to both staff and youth.</p>	<p><b>Compliance</b></p>	<p>The daily programming schedule is clearly posted in a public area and accessible to both staff and youth.</p>

Psychoeducational Groups are conducted a minimum of five days per week using a structured group process model. There is a clear group leader or facilitator identified, and documentation includes the date/time of group, list of participants, length of group, and the topic.	<b>Compliance</b>	Psychoeducational groups are conducted a minimum of five days per week and follow a structured group process model. Each group has a clearly identified leader or facilitator. Group documentation is complete and consistently includes the date and time of the session, length of the group, topic addressed, and a list of participants.
Formal and accessible grievance procedures for youth, including available grievance forms and a locked box, are accessible to youth in a common area.	<b>Compliance</b>	Formal and accessible grievance procedures are in place for youth, including the availability of grievance forms and a locked grievance box located in a common area.
Grievance boxes are checked at least once daily, excluding weekends and holidays) by a member of management or a designated supervisor. Each check is logged in the program's daily logbook, including the date, time, and name of the person conducting the check.	<b>Compliance</b>	All grievances are reviewed, resolved, and documented by the Program Director within 72 hours, with documentation provided for any delays beyond that timeframe.
Only the Program Director/Supervisor has access to and manages grievances unless it is toward themselves (which is escalated to higher leadership).	<b>Compliance</b>	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.	<b>Compliance</b>	All grievances are reviewed, resolved, and documented by the Program Director within 72 hours, with documentation provided for any delays beyond that timeframe.
Grievances are maintained on file for a minimum of one (1) year.	<b>Compliance</b>	Grievances are securely maintained on file for a minimum of one (1) year in accordance with program policy.
<i>Additional Comments: There are no additional comments for this indicator.</i>		
<b>5.1 Shelter Environment</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 5.1</b>		Yes
		The agency has a policy #3.09 Shelter Program Services/Environment which was reviewed and approved by the CEO & COO on 1/16/2026.
The facility is clean, neat, and well-maintained.	<b>Compliance</b>	The facility is consistently clean, neat, and well-maintained throughout all areas.
Furnishings shall be in good repair and maintained as needed.	<b>Compliance</b>	All furnishings are in good repair and suitable for use.
The program is free of insect infestation.	<b>Compliance</b>	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.	<b>Compliance</b>	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.	<b>Compliance</b>	No graffiti or defacement is present on any walls, doors, or windows.
Lighting is adequate for tasks performed there.	<b>Compliance</b>	Lighting is sufficient and appropriate for all activities and workspaces.
Exterior areas are free of debris.	<b>Compliance</b>	Exterior areas are clear of debris and well-kept.
Grounds are free of hazards.	<b>Compliance</b>	Grounds are regularly inspected and free of hazards.
Dumpster and garbage can(s) are covered.	<b>Compliance</b>	Dumpsters and garbage cans are securely covered and properly maintained.
All doors are secure.	<b>Compliance</b>	All facility doors are secure and functioning properly.
In and out access is limited to staff members and key control is in compliance.	<b>Compliance</b>	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.	<b>Compliance</b>	All agency and staff vehicles remain locked when not in use and are equipped with required safety gear, including a stocked first-aid kit, fire extinguisher, flashlight, glass breaker, and seatbelt cutter.
Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted.	<b>Compliance</b>	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.	<b>Compliance</b>	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).	<b>Compliance</b>	Interior spaces are free from contraband or hazardous unauthorized materials, including metal or foreign objects.

<p>All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely. A perpetual inventory is the primary means of maintaining a current and real-time inventory. The weekly inventory is conducted weekly, at a minimum, to ensure that a perpetual inventory is being maintained consistently and accurately. If more than one location is used to store chemicals, there is an inventory wherever chemicals are stored that is current and well-maintained unless previously approved by the Network.</p>	<p><b>Compliance</b></p>	<p>All chemicals are properly listed, approved, stored securely, and inventoried both perpetually and through weekly verification; inventories are accurate and current across all storage areas.</p>
<p>Material Safety Data Sheets (MSDS) are maintained on each chemical item.</p>	<p><b>Compliance</b></p>	<p>Material Safety Data Sheets (MSDS) are maintained and accessible for every approved chemical.</p>
<p>Washer/dryer are operational &amp; general area/lint collectors are cleaned after ever load.</p>	<p><b>Compliance</b></p>	<p>Washers and dryers are operational, and lint collectors are cleaned after each use.</p>
<p>Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket.</p>	<p><b>Compliance</b></p>	<p>Each youth is provided with an individual bed, clean mattress, pillow, and sufficient linens and blankets.</p>
<p>Youth have a safe, lockable place to keep personal belongings, if requested.</p>	<p><b>Compliance</b></p>	<p>Youth have access to a secure, lockable space for personal belongings upon request.</p>
<p><b>Fire Safety and Health Hazards</b></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><b>Compliance</b></p>	<p>The annual fire inspection has been completed, and the facility meets all fire marshal and local code requirements.</p>
<p>Agency completes at least one fire drill on each shift monthly and demonstrates they are within 2 minutes or less.</p>	<p><b>Compliance</b></p>	<p>Fire drills are conducted monthly on each shift, consistently demonstrating safe evacuation within two minutes.</p>
<p>Completes 1 mock emergency drill per shift quarterly, at a minimum.</p>	<p><b>Compliance</b></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><b>Compliance</b></p>	<p>All fire safety equipment, including extinguishers, sprinklers, alarms, kitchen hood systems, and vehicle extinguishers, has current inspection tags and is easily accessible in case of emergency.</p>
<p>The agency has a current Satisfactory Residential Group Care inspection report from the Department of Health.</p>	<p><b>Compliance</b></p>	<p>The facility maintains a current, satisfactory Residential Group Care inspection report from the Department of Health.</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.	<b>Compliance</b>	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.
All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored. Packages in the pantry area are dated upon opening.	<b>Compliance</b>	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.	<b>Compliance</b>	Refrigerators and freezers are clean, maintain required temperatures, and all appliances are operational and sanitary.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>5.2 - Shelter Search Policy</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 5.2</b>		Yes
		The agency has a policy #3.15 Search and Seizure which was last reviewed & approved by the CEO on 1/16/2026.
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.	<b>Compliance</b>	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.	<b>Compliance</b>	Shelter staff conduct searches of outdoor recreational areas before youth access the space to ensure safety and remove potential hazards.
Shelter staff conduct frequent and random searches on each shift.	<b>Compliance</b>	Shelter staff perform frequent and random searches during each shift to maintain a secure and controlled environment.
<b>Additional Comments: During the review, there was no opportunity to witness a live search due to no CINS/ FINS youth being present at the shelter while the reviewers were on the premises. A search of a youth at intake was observed on camera. During the intake process, staff completed a search by going through all the youth's belongings one by one to ensure there was no contraband. Staff also utilized an electronic metal detector wand by requesting the youth to raise both arms, and the wand was used from head to toe of the youth, both in the front and rear of their body. During the search, the staff also had the youth remove their shoes. It was also observed via camera review when the youth returned from school and outing that a staff was conducting searches using the same method.</b>		
<b>5.3 - Logbook Requirements</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 5.3</b>		Yes
		The agency has a policy 5.3 Logbooks which was review by the CEO & COO on 1/16/2026.

Data sources Reviewed	Dates Reviewed	Logbook Format
Program logbooks	7/13/2025 - 7/27/2025, 8/10/2025 - 8/24/2025, 9/7/2025 - 9/21/2025, 10/12/2025 - 10/26/2025, 11/2/2025 - 11/16/2025, 12/1/2025 - 12/15/2025	Paper Log
The program has a process in place to document daily activities, events, and other major occurrences.	<b>Compliance</b>	The program maintains a consistent process to document daily activities, events, and major occurrences.
Safety and security issues that could impact the youth and/or program are highlighted.	<b>Compliance</b>	Safety and security issues that may impact the youth and/or program are clearly identified and highlighted.
All entries are brief and legibly written in ink for paper logbooks.	<b>Compliance</b>	All logbook entries are concise and legibly written in ink.
All entries include: a. Time of incident/activity/event b. Names of youth and staff involved c. Brief statement providing pertinent information d. Signature of person making the entry	<b>Compliance</b>	All entries include the time of the incident or activity, names of youth and staff involved, a brief statement of pertinent information, and the signature of the person making the entry.
All recording errors are struck through with a clear line with staff initial and date.	<b>Compliance</b>	Recording errors are corrected by striking through with a single line and including the staff's initials and date.
The use of white-out is prohibited and all entries are made in ink with no erasures or white out areas for paper logbooks.	<b>Compliance</b>	White-out is not used, and all entries are made in ink with no erasures or alterations.
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry to become aware of any unusual occurrences, problems, etc. and makes an entry signed and dated into the log book indicating the dates reviewed to document the review.	<b>Compliance</b>	At the beginning of each shift, the oncoming supervisor and shelter counselor review prior log entries and document the review with a dated and signed entry.
All direct care staff reviews the logbook at the beginning of each shift for the previous two shifts (at minimum) and include the dates reviewed, which is evidenced by the date and their signature at time of entry.	<b>Compliance</b>	All direct care staff review the logbook at the start of each shift for at least the previous two shifts and document the review with dates and signatures.

Program director or designee reviews the facility logbook(s) every week and makes a note chronologically indicating dates reviewed and if any corrections, recommendations and follow-up is required, which is evidenced by the date and their signature at time of entry.	<b>Compliance</b>	The program director or designee reviews the facility logbook weekly, documenting the review with the date, signature, and any necessary follow-up or recommendations.
Supervision and resident counts are documented.	<b>Compliance</b>	Supervision and resident counts are consistently documented.
Visitation and home visits are documented.	<b>Compliance</b>	Visitation and home visits are clearly documented.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>5.4 - Staffing Standards and Enhanced Supervision</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 5.4</b>		Yes
		The agency has a policy #3.08 Staffing & Enhanced Supervision which was reviewed & approved on 1/16/2026 by the CEO & 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.	<b>Compliance</b>	The program maintains required staffing ratios in accordance with Florida Administrative Code and contract standards, ensuring a minimum of one staff to six youth during awake hours and one staff to five youth during offsite activities.
All shifts consistently maintain a minimum of two (2) staff present. Program staff included in the staff-to-youth ratio includes staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff.	<b>Compliance</b>	All shifts consistently maintain a minimum of two staff members on duty, with staff included in the ratio verified as background-screened and properly trained youth care, supervision, or treatment personnel.
The shelter has implemented policies and procedures to ensure youth safety when being supervised by staff of the opposite sex.	<b>Compliance</b>	The shelter has implemented and follows clear policies and procedures to ensure youth safety when supervised by staff of the opposite sex.
The program staff schedule is provided to staff or posted in a place visible to staff.	<b>Compliance</b>	Staff schedules are provided and/or posted in a visible location to ensure adequate coverage and awareness of staffing assignments.
There is a holdover overtime rotation roster that includes home telephone numbers of staff who may be available when additional coverage is needed.	<b>Compliance</b>	A holdover and overtime rotation roster is maintained and includes contact information for staff available to provide additional coverage as needed.
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction. Times are documented in real time. (The times do not supersede requirements for constant supervision of youth at risk of suicide.)	<b>Compliance</b>	Staff observe youth at least every fifteen (15) minutes while in sleeping rooms, including during sleep periods, illness, or room restriction, with all checks documented in real time.

<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><b>Compliance</b></p>	<p>The program assigns specific staff each shift to monitor the location, behavior, and movement of youth on enhanced supervision, with assignments documented in both the shelter log and staff calendar.</p>
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>		
<p><b>5.5 - Behavior Management Strategies</b></p>		<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 5.5</b></p>	<p>Yes The agency has a policy 3.13 Behavior Management System (Youth Development System) reviewed by the CEO &amp; COO on 1/16/2026.</p>	
<p><b>A Behavior Management Strategy (BMS) is in place:</b></p>		
<p>The program has a detailed written description of the BMS and it is explained during program orientation.</p>	<p><b>Compliance</b></p>	<p>The program maintains a detailed written description of its Behavior Management Strategy (BMS), which is reviewed with youth during program orientation.</p>
<p><b>The written description of the behavioral management strategies include:</b></p>		
<p>A wide variety of positive incentives are used by the program.</p>	<p><b>Compliance</b></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><b>Compliance</b></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><b>Compliance</b></p>	<p>Behavioral interventions are applied immediately, consistently, and proportionate to the severity of the behavior.</p>
<p><b>The Behavior Management Strategy includes:</b></p>		
<p>Consequences for violation of program rules are applied logically and consistently.</p>	<p><b>Compliance</b></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><b>Compliance</b></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><b>Compliance</b></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><b>Compliance</b></p>	<p>Supervisors are trained to monitor staff implementation of behavioral interventions, including point- or level-based systems when applicable.</p>

There is a protocol for providing feedback and evaluation of staff regarding their use of the positive and negative consequences.	<b>Compliance</b>	The program has a clear protocol for providing feedback and evaluation to staff regarding their use of positive and negative consequences.
In general, BMS promotes order, safety, security, respect, fairness, and protection of resident rights.	<b>Compliance</b>	The BMS promotes order, safety, security, respect, fairness, and protection of youth rights throughout the program environment.
BMS provides constructive discipline that encourages youth to meet behavior expectations.	<b>Compliance</b>	The BMS provides constructive discipline that encourages youth to meet and maintain behavioral expectations.
BMS provides for positive reinforcement & recognition; constructive dialogue & peaceful resolution; and minimizes separation of youth from the general population.	<b>Compliance</b>	The BMS emphasizes positive reinforcement, recognition, constructive dialogue, and peaceful conflict resolution while minimizing unnecessary separation from peers.
Disciplinary measures do not deny the youth any of the following: regular meals and snacks, clothing, sleep, physical or mental health services, educational services, exercise, correspondence privileges, or contact with parents/guardians, attorney of record, juvenile probation officer or clergy.	<b>Compliance</b>	Disciplinary measures never deny youth access to meals, clothing, sleep, healthcare, education, exercise, communication privileges, or contact with parents/guardians, attorneys, probation officers, or clergy.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>5.6 - Program Orientation</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 5.6</b>		Yes
		The agency has a policy 5.6 Program Orientation which was reviewed and approved on 1/16/25 by the CEO and COO.
<b>A total of five Program Orientation file(s) were reviewed during this evaluation period. Of these, zero were open and five were closed.</b>		
<b>During the first 24 hours following admission, the program must begin the orientation process, to include:</b>		
Youth received a comprehensive orientation and handbook provided within 24 hours.	<b>Compliance</b>	Youth receive a comprehensive orientation and handbook within the first 24 hours of admission in accordance with program policy.
<b>Youth Orientation is discussed with the youth and includes the following:</b>		
Youth are given a list of contraband items.	<b>Compliance</b>	Youth are provided with a list of contraband items and understand restrictions for safety and security.
Behavioral Expectations and a review of the BMS	<b>Compliance</b>	Behavioral expectations are reviewed in detail, including an explanation of the program's Behavior Management Strategy (BMS).
Dress code explained	<b>Compliance</b>	The program's dress code is explained to youth during orientation.
Review of access to medical and mental health services	<b>Compliance</b>	Youth are informed of available medical and mental health services and how to access them.
Procedures for visitation, mail and telephone	<b>Compliance</b>	Procedures for visitation, mail, and telephone use are reviewed with youth during orientation.
Grievance procedure	<b>Compliance</b>	The program's grievance procedure is explained, including how to file a grievance and access grievance forms.

Disaster preparedness instructions	<b>Compliance</b>	Youth receive disaster preparedness instructions and understand emergency procedures.
Physical layout of the facility	<b>Compliance</b>	Youth are oriented to the physical layout of the facility, including key safety areas and exits.
Sleeping room assignment and introductions	<b>Compliance</b>	Sleeping room assignments are reviewed, and youth are introduced to peers and staff as part of the orientation process.
Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	<b>Compliance</b>	Youth receive suicide prevention information, including how to alert staff if they or others experience suicidal thoughts.
Review of program schedule	<b>Compliance</b>	The daily program schedule is reviewed with youth to promote understanding of structure and expectations.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>5.7 - Youth Room Assignment</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 5.7</b>		Yes
		The agency has a policy 5.7 Youth Room Assignment which was reviewed and approved on 1/16/26 by the CEO and COO.
<b>A total of five Youth Room Assignment file(s) were reviewed during this evaluation period. Of these, zero were open and five were closed.</b>		
<b>The program determines room assignments during admission and intake using the following indicators:</b>		
Review of youth’s history, status & exposure to trauma	<b>Compliance</b>	Youth classification includes a thorough review of the youth’s history, current status, and exposure to trauma to ensure safe and appropriate placement.
Collateral contacts	<b>Compliance</b>	Staff make collateral contacts, as needed, to gather additional information relevant to youth classification and safety.
Initial interactions with and observations of the youth	<b>Compliance</b>	Initial interactions and staff observations of the youth are used to inform room assignments and supervision levels.
Separation of younger youth from older youth	<b>Compliance</b>	Younger youth are housed separately from older youth to promote safety and developmental appropriateness.
Separation of violent youth from non-violent youth	<b>Compliance</b>	Youth with a history of violent behavior are separated from non-violent youth to reduce risk and maintain safety.
Identification of youth susceptible to victimization	<b>Compliance</b>	Youth identified as susceptible to victimization are assigned rooms that promote protection and increased supervision.
Presence of medical, mental, or physical disabilities	<b>Compliance</b>	Youth with medical, mental health, or physical disabilities are appropriately classified to ensure their needs are safely accommodated.
Suicide risk	<b>Compliance</b>	Youth are screened for suicide risk upon admission, and any identified concerns are addressed immediately through safety planning and supervision.

Sexually aggressive and predatory behavior	<b>Compliance</b>	Youth exhibiting sexually aggressive or predatory behaviors are identified and separated to maintain the safety of others.
Acute health symptoms requiring quarantine or isolation	<b>Compliance</b>	Youth presenting acute health symptoms are appropriately quarantined or isolated in accordance with health and safety protocols.
An alert is immediately entered into the program’s alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors.	<b>Compliance</b>	Alerts are immediately entered into the program’s alert system for youth with special needs or risks, including suicide risk, mental health, substance abuse, medical, or security concerns.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>5.8 - Video Surveillance</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 5.8</b>		Yes
		The Program has a policy #4.11 Video Surveillance System and last reviewed and approved on 1/16/2026 by the CEO.
<b>The agency has a system in operation 24 hours a day, 7 days a week. Does it demonstrate:</b>		
A written notice that is conspicuously posted on the premises for the purpose of security; *(for all staff, youth, and visitors, advising if the program has a surveillance system that records both audio and video, indicating consent to audio and video recording). *Effective 12/18/25	<b>Compliance</b>	A written notice indicating video surveillance for security purposes is conspicuously posted on the premises.
Cameras are in the interior (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit (including locations where youth searches are conducted).	<b>Compliance</b>	Cameras are positioned in key interior areas (e.g., intake office, counseling rooms, cafeteria, and dayroom) and exterior locations (e.g., entrances, exits, recreation areas, and parking lots) where youth, staff, and visitors congregate or pass through.
All cameras are visible.	<b>Compliance</b>	All cameras are clearly visible and serve as an effective deterrent to unsafe or prohibited behavior.
No cameras are placed in bathrooms or sleeping quarters.	<b>Compliance</b>	Cameras are not placed in bathrooms or sleeping quarters, ensuring the privacy and dignity of youth and staff.
The system can capture and retain video photographic images, which must be stored for a minimum of 30 days.	<b>Compliance</b>	The video surveillance system captures and retains recordings for a minimum of 30 days in compliance with program requirements.
The system can record date, time, location, and maintain a resolution that enables facial recognition.	<b>Compliance</b>	The system records date, time, and location, maintaining sufficient resolution to enable facial recognition when needed.

Cameras can operate during a power outage.	<b>Compliance</b>	Cameras and recording equipment remain operational during power outages, supported by backup systems.
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel).	<b>Compliance</b>	A current list of designated personnel authorized to access the surveillance system, including off-site access permissions, is maintained and up to date.
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.	<b>Compliance</b>	Supervisory review of surveillance footage is conducted at least once every 14 days, with review periods and findings documented in the facility logbook, including random samples of overnight shifts.
Requests for video recordings pursuant to investigations or quality improvement visits are provided within 24-72 hours of the request.	<b>Compliance</b>	The agency has a policy that video recordings requested for investigations or quality improvement purposes are provided within 24–72 hours of the request.
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. There is evidence that all efforts made to obtain repairs are documented and maintained.	<b>Compliance</b>	Service requests for malfunctioning or inoperable cameras are submitted within 24 hours of discovery, and documentation of repair efforts is maintained for quality assurance.
<b>Additional Comments: There are no additional comments for this indicator.</b>		
<b>Domain Six</b>		
<b>6.0 - Medication Management and Distribution</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 6.0</b>		Yes
		The agency has a policy 3.6 Medication Management-Naloxone Administration approved by the CEO & COO on 1/16/26.
<b>A total of five Medication Management and Distribution file(s) were reviewed during this evaluation period. Of these, zero were open and five were closed.</b>		
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.	<b>Compliance</b>	The agency maintains an active quality improvement process to monitor and enhance medication management and distribution practices, addressing errors and implementing mitigation strategies as needed.
All non-nursing shelter staff designated to assist with the self-administration of medication receive in-person medication administration training: a. provided by a Registered Nurse b. demonstrate competency c. maintain re-certification annually	<b>Compliance</b>	All non-nursing shelter staff designated to assist with self-administration of medications receive in-person training provided by a Registered Nurse, demonstrate competency, and maintain annual re-certification.

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

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

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

<p>Upon admission to shelter services, the youth and parent or guardian (if available) shall be interviewed about the youth's current medications as part of the Medical and Mental Health Assessment screening. This process will be conducted by a Registered Nurse if one is on premises. Otherwise, this interview will be conducted by on-duty staff and reviewed by the Registered Nurse within three (3) business days.</p>	<p><b>Compliance</b></p>	<p>Upon admission, youth and parents or guardians are interviewed regarding current medications as part of the Medical and Mental Health Assessment, conducted by the Registered Nurse or is reviewed by a Registered Nurse within three business days.</p>
<p>Upon intake/admission of a youth, an on-shift certified supervisor of higher level staff will review all medication forms on the next business day. In the event the agency does not have a Registered Nurse, the medication review will be conducted by a certified Leadership position.</p>	<p><b>Compliance</b></p>	<p>All medication forms are reviewed by a certified supervisor or leadership-level staff member on the next business day following youth intake, ensuring proper oversight and compliance with medication procedures.</p>
<p><b>Additional Comments: Observation of a mock medication distribution was conducted due to the program not having any youth in shelter on medication at the time of the review and no youth have been on medication in the last 30 days to observe the practice on program's video surveillance. The program nurse and staff performed a mock demonstration which shows the medication distribution practice is in alignment with the protocol set forth by the Florida Network of Youth and Family Services.</b></p>		
<p><b>6.1 - Naloxone Administration and Opioid Overdose Response</b></p>		<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 6.1</b></p>		<p>Yes</p>
		<p>The Program has a policy #4.11 Video Surveillance System and last reviewed and approved on 1/16/2026 by the CEO.</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><b>Compliance</b></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><b>Additional Comments: There are no additional comments for this indicator.</b></p>		
<p><b>6.2 - Suicide Prevention</b></p>		<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 6.2</b></p>		<p>Yes</p>
		<p>The agency has a policy # 4.08 Suicide Assessment, along with Mental Health &amp; Substance Use Screening reviewed by the CEO &amp; COO on 1/16/26.</p>
<p><b>Shelter maintains a written suicide prevention &amp; response plan approved by the Florida Network.</b></p>		<p>Yes</p>
<p><b>SNAP maintains a written suicide prevention &amp; response plan approved by the Florida Network.</b></p>		<p>N/A</p>
<p><b>Community Counseling maintains a written suicide prevention &amp; response plan approved by the</b></p>		<p>Yes</p>
<p>Upon intake, every youth is screened for suicidality using the five Florida Network questions.</p>	<p><b>Compliance</b></p>	<p>All youth are consistently screened for suicidality during intake using the five Florida Network questions.</p>

<p>Screening results are reviewed, signed by a supervisor, and filed in the youth's case record.</p>	<p><b>Compliance</b></p>	<p>Screening results are reviewed, signed by a supervisor, and accurately filed in each youth's case record.</p>
<p>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.</p>	<p><b>Compliance</b></p>	<p>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.</p>
<p>Assessment of Suicide Risk must be completed and reviewed by the LMHP within 24 hours of a positive screen.</p>	<p><b>Compliance</b></p>	<p>All suicide risk assessments are completed and/or reviewed by an LMHP within 24 hours of a positive screen.</p>
<p>All assessments (initial and follow-up) are documented in detail: youth comments, behaviors, observations, risk indicators, supervision recommendations, treatment/follow-up, and signed and dated by the LMHP.</p>	<p><b>Compliance</b></p>	<p>Assessments are thoroughly documented, capturing all relevant observations, youth statements, risk indicators, and follow-up actions, with proper LMHP signature and date.</p>
<p>If conducted by a non-licensed staff member, the LMHP must co-sign and date as reviewer the next time they are on-site.</p>	<p><b>Compliance</b></p>	<p>When assessments are conducted by non-licensed staff, LMHPs consistently co-sign and date the review during their next on-site visit.</p>
<p>Parents/guardians and the Program Supervisor are notified immediately of any youth determined to be at risk or following a suicide attempt. All notification efforts (in-person, phone, certified mail) are documented in the case file.</p>	<p><b>Compliance</b></p>	<p>Parents/guardians and program supervisors are notified immediately of any youth at risk, and all contact efforts are well-documented in the case file.</p>
<p>If a youth poses an immediate threat to self or others at any time, staff follow Baker Act protocols and/or call 911.</p>	<p><b>Compliance</b></p>	<p>Staff respond appropriately to any immediate threats by following Baker Act protocols or contacting emergency services as required.</p>

<b>Documentation &amp; Family Notification</b>		
All screenings, assessments, supervision actions, and shift-to-shift handoffs are logged in the daily shelter/counseling logbook.	<b>Compliance</b>	All screenings, assessments, supervision activities, and shift-to-shift handoffs are clearly recorded in the daily logbook.
If a guardian cannot be reached in person, telephone contact attempts are documented; and written notice is sent by certified mail.	<b>Compliance</b>	When guardians cannot be reached directly, all phone attempts are documented, and certified letters are sent as required.
When an immediate assessment is not possible, families receive community resource information.	<b>Not Applicable</b>	Assessments occurred immediately in all cases reviewed.
Community Counseling Only: Any screening conducted on school property during school hours is reported to appropriate school authorities.	<b>Not Applicable</b>	No screenings are conducted on school property during school hours.
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.	<b>Compliance</b>	Youth with a positive suicide screen are immediately placed on Constant Sight and Sound Supervision until assessment by a qualified professional occurs.
Residential Only: Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	<b>Compliance</b>	Youth are consistently placed on the appropriate supervision level according to suicide risk assessment results.
Residential Only: Staff document observations (time, behavior notes, warning signs, initials) at intervals no longer than 30 minutes.	<b>Compliance</b>	Staff maintain detailed observation logs every 30 minutes, noting time, behavior, warning signs, and initials.
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.	<b>Compliance</b>	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.
<b>Additional Comments: There are no additional comments for this indicator.</b>		

<b>6.3 - Healthcare Admission Screening</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 6.3</b>		Yes The agency has a policy # 4.12 Medical and Mental Health Alerts / Date reviewed by the CEO & COO on 1/16/2026.
<b>A total of five Healthcare Admissions Screening file(s) were reviewed during this evaluation period. Of these, zero were open and five were closed.</b>		
The primary healthcare screening is completed by the nurse if he/she is present during the intake. If not present during the intake, the nurse reviews the primary healthcare screening within 3 business days.	<b>Compliance</b>	The nurse completes the primary healthcare screening when present at intake, or reviews it within three business days if not on-site.
<b>The primary healthcare screening and observations include:</b>		
Current medications	<b>Compliance</b>	The primary healthcare screening includes verification and documentation of all current medications.
Existing (acute and chronic) medical conditions	<b>Compliance</b>	Existing acute and chronic medical conditions are accurately identified and recorded.
Allergies	<b>Compliance</b>	Any allergies are clearly documented during the screening process.
Recent injuries or illnesses	<b>Compliance</b>	Recent injuries or illnesses are reviewed and noted as part of the assessment.
Observation for evidence of illness, injury, pain or physical distress, difficulty moving, etc.	<b>Compliance</b>	Staff document careful observations for signs of illness, injury, pain, physical distress, or mobility difficulties.
Acute health symptoms requiring quarantine or isolation	<b>Compliance</b>	Youth exhibiting symptoms requiring quarantine or isolation are promptly identified, and appropriate protocols are followed.
Parents are involved with the coordination and scheduling of follow-up medical appointments, as appropriate.	<b>Compliance</b>	Parents and guardians are engaged in coordinating and scheduling follow-up medical appointments as needed.
The program has procedures to include a thorough referral process and a mechanism for necessary follow-up medical care for youth admitted with chronic medical conditions.	<b>Compliance</b>	The program 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.	<b>Not Applicable</b>	The agency has a referral process in place; however, there have been no referrals within the past six months, resulting in no requirement to maintain a daily referral log during that period.
<b>Additional Comments: There are no additional comments for this indicator.</b>		

<b>6.4 - Medical/Mental Health Alert Process</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 6.4</b>		Yes The agency has a policy # 4.12 Medical and Mental Health Alerts / Date reviewed by the CEO & COO on 1/16/2026.
<b>A total of five Medical/Mental Health Alert Process file(s) were reviewed during this evaluation period. Of these, zero were open and five were closed.</b>		
If youth has a medical or mental health condition or allergies, they are appropriately placed on the program's alert system.	<b>Compliance</b>	Youth with medical or mental health conditions or allergies are appropriately flagged in the program's alert system to ensure staff awareness and safety.
Alert system includes precautions concerning prescribed medications and potential side effects.	<b>Compliance</b>	The alert system includes detailed precautions regarding prescribed medications and their potential side effects.
Staff are provided sufficient information/ instructions to recognize/respond to the need for emergency care for medical/mental health problems.	<b>Compliance</b>	Staff receive clear information and instructions enabling them to recognize and appropriately respond to medical or mental health emergencies.
A medical and mental health alert system is in place that ensure information concerning a youth's medical condition, allergies, common side effects of prescribed medication, foods and medications that are contraindicated, or other pertinent mental health treatment information is communicated to all staff.	<b>Compliance</b>	A comprehensive medical and mental health alert system is in place, ensuring that all relevant information, including allergies, medication contraindications, and treatment considerations, is effectively communicated to all staff.
<b>Additional Comments: There are no additional comments for this indicator.</b>		