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

Lutheran Services Florida-Northwest

Hope House-5127 Eastland St., Crestview, Florida 32539
Currie House-4610 W Fairfield Dr., Pensacola, Florida 32506

March 17-19, 2026

EXECUTIVE SUMMARY

A Quality Improvement (QI) monitoring visit was conducted for LSF NW (Currie House and Hope House) for FY 2025-2026 at its program office located at 4610 W Fairfield Dr., Pensacola, Florida. The onsite review is intended to assess the agency's adherence to fiscal, programmatic, and overall contract requirements. LSF NW 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 Laura Moneyham, Florida Network for Youth and Family Services. Agency representatives from LSF NW present for the entrance interview were Jamilyn Newton, Regional Director; Karen Buskey, Shelter Manager; Melissa Woodllums, Clinical Manager; and Lorenzo Brutton, Quality Management Specialist. The last onsite QI visit was conducted on March 5-6, 2025.

In general, the Reviewer found that the AGENCY is in compliance with specific contract requirements. LSF NW received an overall compliance rating of 100% for achieving full compliance with 13/15 indicators of the CINS/FINS Monitoring Tool. There were no recommendations as a result of the monitoring visit; however, one review item rated as conditionally acceptable is awaiting the completion of a corrective plan with another funder.

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 Laura Moneyham by E-mail: laura@floridanetwork.org

2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL

Agency Name: LSF Northwest	**Monitor Name: Laura Moneyham, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office:** 4610 W Fairfield Dr., Pensacola, Florida
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): March 17-19, 2026**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:**	**Notes**
	Unacceptable	**Conditionally Acceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Explain Unacceptable or Conditionally Acceptable:**
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	The program currently has two certified peer reviewers: Kristie Taylor and Erica Bach. Both are scheduled to complete reviews for the current FY 25-26 QI period.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	A list of non-Florida Network contracts was provided.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a	☐	☐	☒	☐	☐	The COI provided included all required coverage. It meets all required limits of coverage based on the agency's COI. Liability Effective 6/1/2025 – 6/1/2026.	

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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. **PTV**							
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **PTV**	☐	☒	☐	☐	☐	The Regional Director reported that they have a current corrective action with DCF for training initiated on 10/27/2025. The estimated completion date is 5/31/2026.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with	☐	☐	☒	☐	☐	The agency has written employee and fiscal policies that comply with GAAP and provide sound internal	

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GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**						controls. Additionally, the agency maintains 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.). **PTV**	☐	☐	☒	☐	☐	Documentation was provided to support this requirement.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	The agency maintains a written policy and procedure for petty cash. The petty cash is reconciled monthly by the Senior Administration Assistant and reviewed by the Regional Director and Staff Accountant. Disbursements and invoices are approved by the Regional Director, and the Staff Accountant (corporate level) conducts reconciliations of the petty case, which is balanced. Additionally, LSF conducts random audits of petty cash statewide.	

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d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. **PTV**	☐	☐	☒	☐	☐	The agency maintains bank reconciliation documents.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has a DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment, an Informational Resources Request (IRR) has been submitted to DJJ. **PTV/ Verify ON SITE**	☐	☐	☐	☐	☒	The Regional Director reported that the agency did not purchase any property with FNYFS funds during FY 25/26 except for 8 HP Pro-books for the SNAP Youth Justice program, which were purchased prior to the commencement of services. The tracking form was observed.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable) **PTV**	☐	☐	☒	☐	☐	Documentation supported the quarterly employer's Federal Tax.	

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g. Budget to actual reports prepared and reviewed by appropriate management. **PTV**	☐	☐	☒	☐	☐	Agency provided budget to actual year-to-date report as of January 31, 2026.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **PTV**	☐	☐	☒	☐	☐	The financial audit was conducted for the year ending December 31, 2024. A separate Management Letter requiring a Corrective Action Plan was not issued by the auditor, as there were no findings and questioned costs.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and	☐	☐	☒	☐	☐	The agency has policies for record storage and retention/disposal. The policy addresses the security of all client files, computers, and disposal of records. Personal information is not easily accessible, and the agency maintains a backup system	

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computer hard drives are wiped prior to discarding. **PTV**						in case of accidental loss of financial information.	
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. **PTV**	☐	☐	☒	☐	☐	A review of agency's current salary list shows evidence that every direct care staff is paid at least $19.00 per hour.	
Disaster Planning k. The agency has a written policy and procedure that includes a policy title/number, date of last review/revision, meets all of the requirements for the indicator that has been approved. The agency has a comprehensive Disaster Preparedness Plan that includes the following: o Emergency evacuation protocols o Severe weather procedures o Evacuation logistics (shelter only) o Evacuation facility designation (shelter only) o Critical Resource Planning	☐	☐	☒	☐	☐	The agency has a written policy and procedure. The policy and procedure meet all requirements.	

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o Florida Network and DJJ notification requirements The Universal Agreement/Emergency Disaster Shelter document is signed by the agency executive. The comprehensive Disaster Preparedness Plan is submitted to the Florida Network annually, no later than February 1st. PTV							

CONCLUSION

LF NW 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 conditionally acceptable or not applicable because 1) the provider has an outstanding corrective plan in process with an outside funder and 2) does not have any current inventory purchased with FY 25/26 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 that meets the standard described in the report findings.

SUMMARY OF CORRECTIVE ACTIONS or RECOMMENDATIONS

No Corrective Actions or Recommendations.

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

Florida Network of Youth and Family Services

Quality Improvement Program Report

LSF NW-Currie House & Hope House

CINS/FINS Programs

Marh 17-19, 2026

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; 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.

<u>Reviewers</u>

Laura Moneyham-QI and Compliance Manager, Florida Network of Youth and Family Services
Kayshala Patterson-Regional Monitor, Department of Juvenile Justice
Wendy Pierre-McNealy-Training Manager, Florida Network of Youth and Family Services
Carrie Connell-Clinical Director, Capital City Youth Services
Krissy Botzong-PQI/Training Director, Anchorage Children's Home

<u>Monitoring Purpose</u>

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.

<u>Program Updates and Notables</u>

Both Currie House and Hope House are undergoing significant renovations and facility upgrades courtesy of community partnerships the programs have developed this fiscal year.

Hope House partnered with the Emerald Coast Association of Realtors 2025 Leadership Team. Through this partnership, the following has been completed: installed a new facility roof, replaced cracked window, provided new blinds throughout shelter, repainted three bedrooms and dayroom, replaced bookshelves with large storage cabinets (filled with games and arts/crafts) and a white board, updated video game area with bean bag chairs, a rug, and video games, recarpeted stairway, redecorated bedrooms with matching sheets, comforters, rugs, and shower curtains, renovated laundry room and replaced two washer/dryer sets. The Emerald Coast Association of Realtors "adopted" the children in care during the holidays and donated clothes, hygiene supplies, and games. Future projects funded by the Association include replacing light fixtures with updated LED fixtures, repainting the stairwell, landscaping front of facility, creating a garden, and refinishing the dining room tables. In a separate partnership with another company, Bath Fitter, the program was able to renovate one of the upstairs youth bathrooms.

Currie House connected to the Escambia County Realtor Association through the program's relationship with the Emerald Coast Association. Current projects include patching drywall throughout the shelter in

preparation for repainting and making fixture repairs. Future projects include repainting the whole shelter, remodeling the ADA compliant bathroom (new flooring, shower, and fixtures), replacing shelter doors/locks, replacing flooring throughout the shelter, replace windows and blinds, replace storage shed, and refinish dining room tables. Upon completion of the facility renovations, the program intends to replace the furniture with funding from a grant.

Currie and Hope House have ZERO medication errors thus far in FY 25/26 and had ZERO medication errors in FY 24/25. The strategies the shelters utilize to prevent medication errors include: assigning a specific staff member responsible for medications on each shift, utilizing alarms to remind staff of medication times, encouraging staff to administer medications within the first 30 minutes of the two-hour window, having the RN attend monthly staff meetings to provide refresher training and having staff call on-call supervisor to confirm medications have been given within time frames. If the staff call is not received by the last 30 minutes of the 2-hour window, the on-call supervisor has an opportunity to call staff and remind them within the timeframe. Staff report that this process has prevented a number of potential errors since implementation.

CINS/FINS Rating Profile

Domain 1: Background Screening and Compliance

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

90 % Indicators Satisfactory 0 % Indicators Limited 10 % Indicators Failed

Domain 3: Screening, Assessment & Case Management

Indicator	Rating
3.2 Admission Process	Satisfactory
3.3 NIRVANA	Limited
3.4 Case Management, Counseling, & Non-Residential Services	Limited
3.5 Adjudication Services-Case Staffing	Not Applicable
3.6 Adjudication Services-CINS Petition Process	Not Applicable
3.7 Service Plans	Satisfactory with Exception(s)
3.8 Youth Records	Satisfactory
3.10 Discharge and Follow-up	Satisfactory

67 % Indicators Satisfactory 33 % Indicators Limited 0 % Indicators Failed

Domain 4: SNAP ® Programs

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

100 % Indicators Satisfactory 0 % Indicators Limited 0 % Indicators Failed

Domain 5: Shelter Program Services

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

88.89 % Indicators Satisfactory 11.11 % Indicators Limited 0 % Indicators Failed

Domain 6: Medical & Mental Health

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

60 % Indicators Satisfactory 20 % Indicators Limited 20 % Indicators Failed

Overall Rating Summary

% Indicators rated Satisfactory: 82.40%
% Indicators rated Limited: 11.80%
% Indicators rated Failed: 5.88%

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

1.4 Training Requirements-Failed: The training files did not consistently have a current tracker for FY 25-26. The tracker found in some files did not include the latest training requirements, such as “Lock Out Protocol,” additionally it did not include a field for Location/Platform of trainings and did not include a section for notations. None of the files included supporting documentation, such as agendas and certificates. The following Pre-service trainings were found to be absent or late in the New Hire files reviewed: One Civil Rights & Federal Funding training was two months late, three Agency Policies and Procedures trainings were late, none of the shelter staff training files included Contraband Overview and Search practices documented, two shelter staff were missing documentation of the Behavior Management System, three files were missing Risk Management training, four files were missing “Its All About Reporting”, three files were missing Building/Facility Layout training, three files were missing File Documentation/Paperwork Requirements training, two files were missing Confidentiality training and one was completed late, five files were missing CCC & Incident Reporting training, three files were missing Child Abuse Reporting training, two files were missing Client Intake & screening, two shelter staff files were missing Client Orientation training, five files were missing Fire Equipment Safety training (both the in-person training and Skill-Pro module), three shelter staff files were missing training on the Medical/Mental Health Alert System, three files were missing Disaster Preparedness training, one shelter staff files was missing Universal Precautions training, two files were missing CPR/First Aid training and three were completed late, one file was missing CINS/FINS training and three were completed late, four shelter staff files were missing Crisis Intervention (MAB), three files were missing the FN Suicide Prevention training and two were completed late, one file was missing Adolescent Development training and one was late, two files were missing Cultural Humility and one was completed late, three files did not have Mental Health/Substance Abuse training and two were completed late. The following Skill-Pro trainings were found to be absent or late in the New Hire files reviewed: one file was missing Child Abuse: Recognition, Reporting, Prevention and two were completed late, one file was missing Equal Employment Opportunity training and three were completed late, three files were missing Human Trafficking Intervention for Direct Care Staff and one was completed late, one file was missing Information Security Awareness and two were completed late, three files were missing Trauma Responsive Practices training and two were completed late. For PREA (Parts 1 & 2) and Sexual Harassment trainings, three were complete late. The following FN training courses were absent or completed late in the files reviewed: six were missing Naloxone training, five files were missing Adverse Childhood Experiences, and six files were missing Statewide Lockout Protocol training. One of six applicable staff files did not contain documentation of medication administration training or Pyxis machine training. For appliable non-licensed clinical staff, the following was missing in the files: documentation of Suicide Assessment training, and documentation and training plan regarding required 52 hours for bachelor’s level staff with less than 2 years’ experience (16 clinical/36 topic specific). For Annual training files, the following was found: the tracker in files did not include all required trainings, location/platform was not a listed field in the trainer tracker, nor a section to include notations, internal trainings were not listed in the program's policy, total hours of completed training were not available and/or up-to-date. The program is developing an updated tracker and process. Of the eight in-service files reviewed, two did not include validated total hours completed. The following training documentation was missing in two or more of the eight annual training files

reviewed: Child Abuse Recognition, Reporting, and Prevention training, Human Trafficking for Direct-Care Staff, Information Security, It' All About Reporting, PREA Parts I & II, Trauma Responsive Practices, Sexual Harassment, FN Youth Suicide Prevention training, and Fire Safety training (in-person and virtual). None of the files contained documentation of reasons for the missed training, nor did they contain supporting documentation of training completed. Half of the Community Counseling/SNAP annual training files did not document completion of at least 24 training hours or the expected completion date of missed training. Half of shelter staff files reviewed did not document completion of at least 40 hours of annual training.

3.3 NIRVANA (Network Inventory of Risks, Victories, and Needs Assessment)-Limited: Three of ten files reviewed did not have NIRVANA entered into NetMIS within three business days. For four of ten files reviewed, the supervisor's signature predated the assessment print date, and the review date could not be verified, and for three files the supervisor signature was missing. One applicable file had a 90-day re-assessment completed late.

3.4 Case Management, Counseling & Non-Residential Services-Limited: Two residential and two community counseling files did not contain documentation of individual or family counseling occurring weekly and no documentation was provided as to the reason for the missed sessions. Half of the files reviewed did not have all sessions documented in both the youth's file and in NetMIS. Supervision was not offered on a consistent weekly basis and there was no documentation as to why supervision was not conducted. The forms for supervision were not consistently completed, and one counselor had no documentation of supervision sessions.

5.0 Shelter Program Services-Limited: Psycho-educational groups were not provided five times per week. Supervisor checks of grievance boxes were not documented as occurring daily (except weekends/holidays), Hope House was missing documentation for six days and Currie House was missing documentation for 25 days. Currie House did not maintain grievance forms for at least one year.

6.2 Suicide Prevention-Limited: The following documentation was missing in two of six files reviewed: screening results reviewed and signed by a supervisor, suicide risk-assessment completed within 24 hours of positive screening, and parent/guardian notification of suicide risk. One file did not contain as assessment completed by an LMHP. There was no documentation found in the logbook regarding screening, assessments, or supervision actions for four of the residential files with positive suicide screening results. For two of the youth, it could not be determined by documentation in the logbook or the file if sight/sound supervision was initiated. Two youth on sight/sound supervision had observations more than 30 minutes apart.

6.3 Medical/Mental Health Alert Process-Failed: The program's practice does not match its policy which resulted in missing a high-risk alert for a youth.

Methodology

This review was conducted in accordance with FDJJ-2000 (Quality Assurance Policy and Procedures) and focused on the areas of Doman 1-Doman 6, which are included in the Florida Network of Youth and Family Services 2025-2026 Policy and Procedure Manual (effective July 1, 2025, and updated January 2026).

Persons Interviewed

	Chief Executive Officer	X	Case Manager (SNAP)	X	Nurse-Full time
	Chief Financial Officer	X	Counselor non-licensed		Nurse-Part-time
	Chief Operating Officer		Advocate	X	Program Supervisor/s
X	Executive/Regional Director	X	Direct Care-Full time	X	Food Service Personnel
	Program Director		Direct Care- Part-time		Healthcare Staff
	Program Manager		Direct Care- PRN	X	Maintenance Personnel
	Clinical Director		Intern		Other:
X	Program Coordinator		Volunteer		
X	Counselor Licensed	X	Human Resources		

Documents Reviewed

	Accreditation Report	X	Grievance Process	X	Youth Handbook
X	Affidavit of Character		Key Control	5	# Health Records
X	CCC Reports	X	Fire Drill Log	10	# Employee/Intern/Volunteer Records
X	Logbooks	X	Medical/MH Alerts	19	# Training Records
X	Continuity of Operation Plan	X	Precautionary Observation	16	# Youth Records (Closed)
X	Egress Plan	X	Program Schedules	16	# Youth Records (Open)
X	Fire Inspection Report	X	List of additional contracts		Other:
X	Table of Organization	X	Vehicle Insurance		
X	Fire Prevention Plan	X	Visitation Logs		

Observations

	Intake	X	Staff Supervision of Youth	X	Posting of Abuse Hotline #
X	Program Activities	X	Facility & Grounds		Tool Inventory & Storage
	Recreation	X	First Aid Kits	X	Toxic Item Inventory & Storage
X	Searches		Group		Treatment Team Meetings
X	Video Surveillance Tapes		Meals	X	Youth Movement & Counts
	Social Skills Modeling	X	Census Board	X	Staff Interactions with Youth
X	Medication Administration		Discharge	X	Signage that all youth are welcome

Surveys

4	# of Youth	5	# of Staff		# of Others

QUALITY IMPROVEMENT PROGRAM REPORT VALIDATION & CERTIFICATION

Program Name: Lutheran Services Florida- Currie House & Hope House

Service Type(s): SNAP UNDER 12 | SNAP YOUTH JUSTICE | SHELTER | CINS/FINS | SNAP FOR SCHOOLS

Dates of Review: 3/18/2026-3/19/2026

Date Report Received: 4/7/2026 **Date Certification Completed:** 4/8/2026

Domain Indicator	Indicator Name	Current Rating	Agreement w/ Report Rating	Revised Rating	Disagreement Justification
1.0	Background Screening & Compliance	SATISFACTORY WITH EXCEPTIONS	YES		
1.1	Annual Affidavit of Compliance w/ Good Moral Character Standards	SATISFACTORY	YES		
1.2	Provision of an Abuse Free Environment	SATISFACTORY	YES		
1.3	Incident Reporting	SATISFACTORY WITH EXCEPTIONS	YES		
1.4	Training Requirements (Policy & New Hire)	FAILED	YES		
1.5	Data Entry & Collection	SATISFACTORY	YES		
1.6	Risk Management/Analyzing and Reporting	SATISFACTORY WITH EXCEPTIONS	YES		
1.7	Client Transportation	SATISFACTORY	YES		
1.8	Client Contact	SATISFACTORY WITH EXCEPTIONS	YES		
1.9	Outreach Services	SATISFACTORY	YES		
3.0	Screening for Eligibility Policy	N/A			
3.1	Centralized Intake	N/A			
3.2	Admission Process	SATISFACTORY	YES		
3.3	NIRVANA	LIMITED	YES		
3.4	Case Management, and Service Delivery	LIMITED	YES		
3.5	Adjudication Services: Case Staffing	N/A			
3.6	Adjudication Services: CINS Petition Process	N/A			
3.7	Case/Service Plan	SATISFACTORY WITH EXCEPTIONS	YES		
3.8	Youth Records	SATISFACTORY	YES		
3.9	Shareet Cares Demonstration Project	N/A			
3.10	Discharge and Follow Up	SATISFACTORY	YES		
4.0	SNAP® Under 12	SATISFACTORY WITH EXCEPTIONS	YES		
4.1	SNAP® Fidelity Monitoring	SATISFACTORY	YES		
4.2	SNAP® for Youth	N/A			
4.3	SNAP® Youth Justice	SATISFACTORY WITH EXCEPTIONS	YES		
4.4	SNAP® Under 12 Case Management Services for Fathers	N/A			
4.5	SNAP® for Schools and Communities	SATISFACTORY	YES		
5.0	Shelter Program Services	LIMITED	YES		
5.1	Shelter Environment	SATISFACTORY WITH EXCEPTIONS	YES		
5.2	Shelter Search Policy	SATISFACTORY WITH EXCEPTIONS	YES		
5.3	Lookbook Requirements	SATISFACTORY WITH EXCEPTIONS	YES		
5.4	Staffing Standards and Enhanced Supervision	SATISFACTORY WITH EXCEPTIONS	YES		
5.5	Behavior Management Strategies	SATISFACTORY WITH EXCEPTIONS	YES		
5.6	Program Orientation	SATISFACTORY WITH EXCEPTIONS	YES		
5.7	Youth Room Assignment	SATISFACTORY WITH EXCEPTIONS	YES		
5.8	Video Surveillance	SATISFACTORY WITH EXCEPTIONS	YES		
6.0	Medication Management and Distribution	SATISFACTORY	YES		
6.1	Naloxone Administration and Opioid Overdose Response	SATISFACTORY	YES		
6.2	Suicide Prevention	LIMITED	YES		
6.3	Healthcare Admission Screening	SATISFACTORY WITH EXCEPTIONS	YES		
6.4	Medical/Mental Health Alert Process	FAILED	YES		
Overall	Final Percent of Indicators Rated Satisfactory	82.40%			
Overall	Final Percent of Indicators Rated Limited	11.80%			
Overall	Final Percent of Indicators Rated Failed	5.90%			

Certified By: Katherine Jankowski

CINS/FINS QUALITY IMPROVEMENT TOOL		
Quality Improvement Indicators and Results: Compliance: The findings observed or reviewed indicate the practice is aligned with the requirement(s) for the review item at the time of the review. Exception: The findings observed or reviewed indicate the practice is not aligned with the requirement(s) for the review item at the time of the review. Not Applicable: The item reviewed is not applicable for this review item(s) or the agency is not contracted to provide services related to the review item. E.g. If the agency has a policy that states they will not transport under any circumstance, Indicator 1.06 would be not applicable.		**Summary/Narrative Findings:** This column provides a comprehensive narrative summary of each assigned QI indicator. It highlights areas where the program demonstrated compliance, outlines the evidence supporting those determinations, and provides detailed explanations for any deficiencies or exceptions. Together, these findings offer clear justification for the specific domain ratings and present a balanced view of program performance.
Domain One – Background Screening and Compliance		
1.0 - Background Screening		**Satisfactory with Exception/s**
Provider has a written policy and procedure that meets the requirement for Indicator 1.0		Yes; 1.01 Background Screening of Employees, Interns and Volunteers; 03/10/2026
Provider has implemented a Suitability Assessment policy and procedure that meets the requirement for Indicator 1.0		Yes
A total of 11 file(s) were reviewed during this evaluation period. Of these 11 new hire file(s) and zero 5-year rescreen file(s) were reviewed. The sample included nine employee(s) and two volunteers.		
Suitability Assessment		
All positions providing direct services (residential and community counseling) to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	All staff providing direct services to youth successfully passed the pre-employment suitability assessment on their initial attempt.
For any applicant that did NOT pass the initial suitability assessment: Applicant retook the assessment and passed within five (5) business days of the initial attempt, not to exceed three (3) attempt within thirty (30) days.	**Not Applicable**	All applicants passed the suitability assessment on the initial attempt.
Did the applicant pass the suitability assessment?	**Not Applicable**	All applicants passed the suitability assessment on the initial attempt.
Employees who have a break in service may be reemployed with the same agency without an additional suitability assessment if the break is less than eighteen (18) months. However, if the provider changed or updated the assessment tool used, there is evidence that the employee completed the new assessment.	**Not Applicable**	None of the employees reviewed had a break in service.
New Hire		
For New Hires-The background screening was completed and the applicant was determined eligible prior to the date of hire.	**Compliance**	Background screenings for all new hires were completed, and eligibility was confirmed prior to each hire date.
For employee, contractor, volunteer, or intern who provide services for ten (10) or more hours per month-The background screening was completed and volunteer/mentor or intern determined eligible prior services being provided.	**Exception**	One volunteer did not complete a background screening prior to hire/start date.
For those with ineligible background screenings, the exemption was obtained prior to working with youth.	**Not Applicable**	There were no individuals requiring exemptions.
E-Verify		

The file contains proof of E-Verify for all new employees obtained from the Department of Homeland Security.	**Compliance**	All personnel files contained valid E-Verify confirmations from the Department of Homeland Security verifying employment eligibility.
5 Year Rescreening		
Five year re-screening was completed prior to the 5-year anniversary date of initial hire or prior to expiration of retained fingerprints date.	**Not Applicable**	None of the staff files reviewed required a 5 year rescreening.
Additional Comments: Provider provided documentation which indicates the volunteer did not complete a background screening prior to hire/start date due to being cleared by DCF/AHCA and having an eligible rating however, results from DJJ/AHCA were not completed.		
1.1 - Annual Affidavit of Compliance with Good Moral Character Standards		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.1		Yes 1.01 Background Screening of Employees, Interns and Volunteers; 03/10/2026
Affidavit of Annual Compliance with Level 2 Screening Standard (Form IG/BSU-006) is completed and submitted to BSU by January 31st.	**Compliance**	The Affidavit of Annual Compliance with Level 2 Screening Standard (Form IG/BSU-006) was completed and submitted to BSU by the required deadline of January 31.
Affidavit of Annual Compliance with Level 2 Screening Standard was submitted sent to BSU by (at minimum): a. fax confirmation b. email confirmation	**Compliance**	Each affidavit submission included documented proof of delivery to BSU, verified through fax or email confirmation.
1.2 - Provision of an Abuse Free Environment		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.2		Yes 1.02 Provision of an Abuse Free Environment; 03/10/2026
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.	**Compliance**	The program maintains a formal code of conduct that strictly prohibits physical abuse, profanity, threats, intimidation, and other inappropriate behavior. The code of conduct is provided to all staff, with documented acknowledgment of receipt.
The Child Abuse Hotline number is clearly posted and visible for youth and staff to see.	**Compliance**	The Child Abuse Hotline number is clearly posted in visible locations accessible to both youth and staff.
The program has a process in place for reporting and documenting any child abuse hotline calls.	**Compliance**	The program has an established process for promptly reporting and documenting all child abuse hotline calls in accordance with state and agency policy. Staff are trained and compliant with reporting procedures.
The agency is an abuse free environment.	**Compliance**	Survey feedback confirms the agency maintains an abuse-free environment, with no reported concerns from staff or youth.
1.3 - Incident Reporting		**Satisfactory with Exception/s**
Provider has a written policy and procedure that meets the requirement for Indicator 1.3		Yes 1.03 Incident Reporting; 03/07/2026
Data sources Reviewed	**Dates Reviewed**	**Logbook Dates for Sample Size:**

CCC Reports and Log Book entries	09/18/2025-03/18/2026	09/18/2025-03/18/2026
The program notified the Department's CCC and reportable incidents were consistently reported as required, no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident.	**Exception**	A review of the documentation indicated four out of twenty-five incidents were not reported to the Department's CCC within the required timeframe.
The program completes follow-up communication tasks/special instructions as required by the CCC.	**Compliance**	The program completed all follow-up communication and special instructions from the CCC.
Incidents are documented in the program logs, and the CCC call is documented in the logbook for Shelter programs.	**Exception**	A review of the documentation indicated one out of twenty-five incidents were not documented in the logbook for Shelter programs.
Agency internal incidents are documented on incident reporting forms or electronically and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	Agency internal incidents are consistently documented using approved incident reporting forms or electronic systems, and all CCC-reportable incidents are reported to the CCC in accordance with established requirements.
All incident reports are reviewed and signed by program supervisors/directors.	**Compliance**	All incident reports were reviewed and signed by program supervisors or directors.
1.4 - Training Requirements		**Failed**
Provider has a written policy and procedure that meets the requirement for Indicator 1.4		No The program's training policy excludes required trainings and hours. No clear documentation of when a staff begins to work independently, how this is tracked, documenting intern and volunteer duties/degrees and required trainings and supervision of those who are non-licensed.
A total of two first-year non-licensed Mental Health Clinical Shelter staff file(s) were reviewed. 11 new hire staff and eight annual staff files were reviewed for compliance with training completed within the required		
Policy & New Hire Training		
Trainings that are required by the Network and other funders must be documented in each individual staff member's file and on the FLN Training Log or similar document with the minimum requirements i.e. Staff Name & Position, Date of Hire, Training anniversary used by agency (calendar, date of hire or fiscal), Training Name, Training Hours, Cumulative Total, Training Completion or Facilitation Date, Location of Training or Platform Used (when virtual).	**Exception**	Training files reviewed did not consistently have a current tracker for FY 25-26. The tracker in files did not include all required trainings such as Lock Out Protocol. Location/Platform was not a listed field in the trainer tracker, nor a section to include notations. Internal trainings were not listed in the program's policy. Two in-service files had the most up-to-date training tracker.
Civil Rights & Federal Funds (United States Department of Justice) (Required within 30 DAYS of date of hire)	**Exception**	Of the 11 files reviewed, one did not have this course completed within the required timeframe. The staff completed the training two months late and there was no notation documented in the tracker.
Pre-Service Training		
Agency policies and procedures	**Exception**	Of the 11 files reviewed, three new hire files did not have documentation of completing this training during orientation. There were no notations documented in the tracker, as required.

Contraband Overview and Search Policy/Practice AND signed acknowledgment form by staff.	**Exception**	During the review period, none of the trackers outlined contraband training with staff signature. The tracker was updated during the review. The review team could not validate the completion dates for the trainings in the reviewed files. The program provided an example of some completion for all new hire orientation topics; however this was not consistently available for the reviewed files.
Behavior Management	**Exception**	Of the 10 applicable new hire files reviewed, two did not have documentation of completion. There were no notations documented in the tracker, as required.
Risk Management	**Exception**	Of the 11 applicable new hire files reviewed, three did not have documentation of completion. There were no notations documented in the tracker, as required.
It's All About Reporting	**Exception**	Of the 11 applicable new hire files reviewed, four did not have documentation of completion. There were no notations documented in the tracker, as required.
Building/Facility layout	**Exception**	Of the 11 applicable new hire files reviewed, three did not have documentation of completion. There were no notations documented in the tracker, as required.
File Documentation/Paperwork Requirements	**Exception**	Of the 11 applicable new hire files reviewed, three did not have documentation of completion. There were no notations documented in the tracker, as required.
Confidentiality (FYSB / DCF / Skill Pro)	**Exception**	Of the 11 applicable new hire files reviewed, two did not have documentation of completion and one was completed late (due 2/4/26 and completed on 3/21/26). There were no notations documented in the tracker, as required.
CCC & Incident Reporting	**Exception**	Of the 11 applicable new hire files reviewed, five did not have documentation of completion. There were no notations documented in the tracker, as required.
Child Abuse Reporting	**Exception**	Of the 11 applicable new hire files reviewed, three did not have documentation of completion. There were no notations documented in the tracker, as required.
Client Intake & Screening	**Exception**	Of the 10 applicable new hire files reviewed, two did not have documentation of completion. There were no notations documented in the tracker, as required.
Client Orientation (Shelter only)	**Exception**	Of the 10 applicable new hire files reviewed, two did not have documentation of completion. There were no notations documented in the tracker, as required.
Fire Safety Equipment (In-person by a supervisor or other program trainer)	**Exception**	Of the 10 applicable new hire files reviewed, five did not have documentation of completion. There were no notations documented in the tracker, as required.
Fire Safety Equipment (Skill Pro #215 or DCF)	**Exception**	Of the 10 applicable new hire files reviewed, five did not have documentation of completion one was completed late (due 2/4/26 and completed on 3/21/26). There were no notations documented in the tracker, as required.
Medical and Mental Health Alert System	**Exception**	Of the 10 applicable new hire files reviewed, three did not have documentation of completion. There were no notations documented in the tracker, as required.
Disaster Preparedness	**Exception**	Of the 11 applicable new hire files reviewed, three did not have documentation of completion. There were no notation documented in the tracker, as required.
Universal Precautions / Communicable Diseases / Infection Control / Bloodborne Pathogens Part I & II	**Exception**	Of the 10 applicable new hire files reviewed, one did not have documentation of completion. There were no notations documented in the tracker, as required.
CPR/First Aid (By CPR Certified Instructor)	**Exception**	Of the 11 applicable new hire files reviewed, two did not have documentation of completion and three were completed late. There were no notations documented in the tracker, as required. Program did not provide validated documentation such as a certificate and/or sign in sheet.

Video Camera Surveillance & Equipment	**Not Applicable**	None of the staff files reviewed have access to the video camera surveillance and equipment.
CINS/FINS Core	**Exception**	Of the 11 files reviewed, one did have documentation of completion for CINS/FINs Core and three were completed late.
Crisis Intervention [e.g., MAB (2-day/16 hours)]	**Exception**	Of the six applicable new hire files reviewed, four did not have documentation of completion. There were no notations documented in the tracker, as required.
Florida Network Youth Suicide Prevention	**Exception**	Of the 10 applicable new hire files reviewed, three did not have documentation of completion and two were completed late. There were no notations documented in the tracker, as required.
Adolescent Development / Positive Youth Development	**Exception**	Of the 10 applicable new hire files reviewed, one did not have documentation of completion and one was completed late. There were no notations documented in the tracker, as required.
Cultural Humility/Diversity	**Exception**	Of the 10 applicable new hire files reviewed, two did not have documentation of completion and one was completed late. There were no notations documented in the tracker, as required.
Mental Health and Substance Abuse	**Exception**	Of the 10 applicable new hire files reviewed, three did not have documentation of completion and two were completed late. There were no notations documented in the tracker, as required.
Skill Pro Required Trainings:		
Child Abuse: Recognition, Reporting and Prevention	**Exception**	Of the 11 applicable new hire files reviewed, one did not have documentation of completion and two were completed late. There were no notations documented in the tracker, as required.
Equal Employment Opportunity	**Exception**	Of the 11 applicable new hire files reviewed, one did not have documentation of completion and three were completed late. There were no notations documented in the tracker, as required.
Human Trafficking Intervention for Direct Care Staff	**Exception**	Of the 11 applicable new hire files reviewed, three did not have documentation of completion and one was completed late. There were no notations documented in the tracker, as required.
Information Security Awareness	**Exception**	Of the 11 applicable new hire files reviewed, one did not have documentation of completion and two were was completed late. There were no notations documented in the tracker, as required.
Prison Rape Elimination Act (PREA) - Part 1	**Exception**	Of the 11 applicable new hire files reviewed, two were completed late. There were no notations documented in the tracker, as required.
Prison Rape Elimination Act (PREA) - Part 2	**Exception**	Of the 11 applicable new hire files reviewed, two were completed late. There were no notations documented in the tracker, as required.
Sexual Harassment	**Exception**	Of the 11 applicable new hire files reviewed, three were completed late. There were no notations documented in the tracker, as required.
Trauma Responsive Practices	**Exception**	Of the 11 applicable new hire files reviewed, three did not have documentation of completion and two were completed late. There were no notations documented in the tracker, as required.
Additional FL Network Required Trainings:		
Naloxone Training	**Exception**	Of the 11 applicable new hire files reviewed, six did not have documentation of completion. There were no notations documented in the tracker, as required.

Adverse Childhood Experiences (ACEs) (Required for All Staff not completing NIRVANA)	**Exception**	Of the 10 applicable new hire files reviewed, five did not have documentation of completion and one was completed late. There were no notations documented in the tracker, as required.
FL Statute 984 CINS Petition Training (Case Staffing & CINS Petition Staff Only)	**Not Applicable**	Files reviewed did not indicate if the staff/position participates in case staffing and CINS petition.
Statewide Lockout Protocol	**Exception**	Of the seven applicable new hire files reviewed, six did not have documentation of completion. There were no notations documented in the tracker, as required.
STAFF SPECIFIC TRAINING - Florida Network and SkillPro Required Trainings Related to Specific Staff Roles		
JJIS (Juvenile Justice Information System) System Access (Required for staff who enter and monitor SVS prior to accessing JJIS)	**Not Applicable**	None of the staff files reviewed enter and monitor SVS requiring JJIS System Access training.
JJIS Alerts – Part 1 (JJIS Data Entry Staff prior to accessing JJIS)	**Compliance**	Although the reviewed files did not indicate if the staff/position required access to the JJIS system, 10 new hired staff files included the completion of this trainings.
JJIS Alerts – Part 2 (JJIS Data Entry Staff prior to accessing JJIS)	**Compliance**	Although the reviewed files did not indicate if the staff/position required access to the JJIS system, 10 new hired staff files included the completion of this trainings.
Motivational Interviewing (MI) (Prior to NIRVANA training for Staff who Administer the NIRVANA)	**Compliance**	Staff responsible for administering the NIRVANA® completed Motivational Interviewing (MI) training prior to NIRVANA® instruction.
NIRVANA Assessment (Required for all staff who Administer the NIRVANA, prior to administering the NIRVANA)	**Compliance**	Staff assigned to conduct NIRVANA® assessments completed NIRVANA® training prior to administering the assessment, verified with the Lead.
Medication Distribution for Shelter Staff Without a Medical License (Prior to administration of medication and annually)	**Exception**	According to the RN, all YCS staff are trained in medication management and Pyxis machine. Of the six applicable new hire staff files reviewed, one did not have did not have documentation of completion or registration listed in the RN's sign up sheet.
PYXIS (Authorized Shelter Staff prior to accessing Pyxis system)	**Exception**	According to the RN, all YCS staff are trained in medication management and Pyxis machine. Of the six applicable new hire staff files reviewed, one did not have did not have documentation of completion or registration listed in the RN's sign up sheet.
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	**Compliance**	Staff participating in SNAP® Support Overview completed training prior to assisting groups and were paired only with certified SNAP® facilitators.
SNAP Facilitator Training (Required for All Staff prior to the delivery of Groups)	**Compliance**	All SNAP® facilitators completed SNAP® Facilitator Training prior to delivering groups, with retraining documented if facilitation lapsed beyond one year.
NetMIS Training (For NetMIS Users prior to accessing NetMIS)	**Compliance**	NetMIS users completed NetMIS training prior to being granted system access.

NON-LICENSED CLINICAL STAFF ONLY Staff Suicide Assessment Training ** 20 hours including a minimum of five (5) one-to-one assessments of suicide risk in the physical presence of a licensed professional. This training is documented and maintained in the staff person's personnel file using the Documentation of Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk form. (Required for All shelter staff who are not licensed prior to independent assessment of suicide risk)	**Exception**	None of the 3 applicable files reviewed contained documentation of completion of Suicide Assessment Training.
NON-LICENSED CLINICAL STAFF ONLY 16 hours clinical training + 36 hours topic-specific training (Covering: basic counseling skills, basic group therapy skills, treatment model and program philosophy, therapeutic milieu, behavior management, client rights, crisis intervention, early intervention and de-escalation, documentation requirements, normal and abnormal adolescent development, typical behavior problems) * Prior to working with youth*	**Exception**	Although there were two applicable new hire staff files reviewed in-progress, there was no documentation of completion or tracking of these sessions or training plan.
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*	**Exception**	Although there were two applicable new hire staff files reviewed in-progress, there was no documentation of completion or tracking of these sessions or training plan.
For any trainings that are NOT completed within the required timeframe, includes documentation of the reason and scheduled completion date.	**Exception**	None of the 11 reviewed new hire staff files contained documentation, updated tracker for current FY that include accurate due date and/or expected completion date.
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.	**Exception**	No consistent tracking of training hours across all delivery types in training files/trackers; as well as no recording of when a staff works independently and/or added to ratio. At the time of review, two new hire files recorded at least 80 hours of completed training.
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.	**Exception**	Documentation of internal promotion and/or transfers from other programs or DJJ provider or respective gaps in service, were not included in reviewed files.
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.	**Exception**	Required documentation was not included in the 11 reviewed new hire staff files.

The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Compliance**	The agency has a designated staff member responsible for managing all employee training files.
All Network-required training is supported by documentation such as certificates, sign-in sheets, and agendas.	**Exception**	Supporting documentation was not included in the 11 reviewed new hire staff files.
Annual Training		
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)	**Exception**	Training files and trackers reviewed did not consistently have a current tracker for FY 25-26. The tracker in files did not include all required trainings, location/platform was not a listed field in the trainer tracker, nor a section to include notations. Internal trainings were not listed in the program's policy. Total hours of completed trainings were not available and/or up-to-date. The program is developing an updated tracker and process. Of the 8 in-service files reviewed, two did not include validated total hours completed.
Child Abuse: Recognition, Reporting, and Prevention (Annually)	**Exception**	Of the eight applicable in-service staff files reviewed, three had no documentation of completion. There were no notations documented in the tracker, as required.
Human Trafficking Intervention for Direct-Care Staff (Annually)	**Exception**	Of the eight applicable in-service staff files reviewed, three had no documentation of completion. There were no notations documented in the tracker, as required.
Information Security Awareness (Annually)	**Exception**	Of the eight applicable in-service staff files reviewed, five had no documentation of completion. There were no notations documented in the tracker, as required.
It's All About Reporting	**Compliance**	It's All About Reporting is completed annually and supported by appropriate documentation.
Prison Rape Elimination Act (PREA) Part 1 (Every 2 years)	**Exception**	Of the eight applicable in-service staff files reviewed, two had no documentation of completion. There were no notations documented in the tracker, as required.
Prison Rape Elimination Act (PREA) Part 2 (Every 2 years)	**Exception**	Of the eight applicable in-service staff files reviewed, two had no documentation of completion. There were no notations documented in the tracker, as required.
Sexual Harassment (Every 2 Years)	**Exception**	Of the eight applicable in-service staff files reviewed, two had no documentation of completion. There were no notations documented in the tracker, as required.
Trauma Responsive Practices (Every 2 Years)	**Exception**	Of the eight applicable in-service staff files reviewed, two had no documentation of completion. There were no notations documented in the tracker, as required.
FL Network Annual Required Trainings REQUIRED for Staff Over 1 year		
Florida Network Youth Suicide Prevention (Required Annually)	**Exception**	Of the eight applicable in-service staff files reviewed, two had no documentation of completion. There were no notations documented in the tracker, as required.
CPR (Every 2 Years - Check for current validity)	**Compliance**	Although all eight applicable reviewed in-service files included completion of this training, one did not include documentation to validate.
First Aid (Every 2 Years - Check for current validity)	**Compliance**	Although all eight applicable reviewed in-service file included completion of this training, one did not include documentation to validate.
Crisis Intervention training approved by the Network (ex: Managing Aggressive Behavior (MAB) (Every 2 Years)	**Compliance**	Crisis Intervention training (e.g., Managing Aggressive Behavior – MAB) is completed every two years as approved by the Network.
In-Person Fire Safety Equipment (Every 2 years)	**Exception**	Of the four applicable in-service staff files reviewed, none had no documentation of completion. There were no notations documented in the tracker, as required.

Virtual Fire Safety Equipment (Every 2 years)	**Exception**	Of the four applicable in-service staff files reviewed, none had no documentation of completion. There were no notations documented in the tracker, as required.
Medication Distribution for Staff Without a Medical License (Re-certification annually)	**Compliance**	Medication Distribution training for staff without a medical license is re-certified annually and verified through documentation.
SNAP Refresher Training (Annually for all staff who have completed SNAP Facilitator Training and are delivering SNAP group services or monitoring fidelity)	**Compliance**	SNAP® Refresher Training is completed annually for all staff delivering SNAP® group services or conducting fidelity monitoring.
For missed trainings, documentation includes the reason for delay and scheduled completion timeline.	**Exception**	Of the six applicable in-service staff files reviewed, none had no documentation of completion or expected completion date. There were no notations documented in the tracker, as required.
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.	**Exception**	Of the two applicable in-service staff files reviewed, one had no documentation of completion of at least 24 hours or expected completion date. There were no notations documented in the tracker, as required. The review team was provided the total hours for the reviewed SNAP in-service staff members.
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.*	**Exception**	Of the four applicable in-service staff files reviewed, two had no documentation of completion of at least 40 hours or expected completion date. There were no notation documented in the tracker, as required.
Annual and Biannual training must be due on a calendar or fiscal year basis, not based on hire date.	**Compliance**	Annual and biannual training schedules are tracked and completed based on the agency's established calendar or fiscal year cycle, not hire date.
All Network-required training is supported by documentation such as certificates, sign-in sheets, and agendas.	**Exception**	Supporting documentation was not included in the 8 annual training files reviewed.
1.5 - Data Entry & Collection		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.5		Yes 1.5 Analyzing and Reporting, reviewed and approved by Regional Director 10/25/25 and updated/approved by Regional Director 3/18/2026. Data entry language is included in the Analyzing and Reporting policy, however upon initial review it was not readily apparent. Regional Director revised policy to highlight data reporting requirements.
The program has a quality improvement process in place that includes designated staff responsibilities to ensure data accuracy and quality.	**Compliance**	The program maintains an active quality improvement process to review and enhance the accuracy of data entry and collection.
Client and service data is entered electronically into the Florida Network Management Information System (NetMIS) within three (3) business days of service commencement.	**Compliance**	Client and service data are entered electronically into the Florida Network Management Information System (NetMIS) within three (3) business days of service commencement, as verified in the most recent End-of-Month (EOM) report.
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.	**Compliance**	Monthly review of statewide End-of-Month (EOM) reports is completed and documented, including analysis of monthly data, fiscal year-to-date data, benchmarks, screening metrics, report card measures, and follow-up reporting indicators.
1.6 - Risk Management/ Analyzing and Reporting Information		**Satisfactory with Exception/s**

Provider has a written policy and procedure that meets the requirement for Indicator 1.6		Yes 1.5 Analyzing and Reporting Information, approved by Regional Director on 10/25/25.
Data sources Reviewed		**Dates Reviewed**
Policy Manual, CQI Meeting minutes, CINS/FINS Monthly Performance Call agendas, interview with Regional Director		CQI meeting minutes 2/11/26, 12/10/26, 11/6/25, BOD Meeting Minutes-1/28/26, 10/3/25, 7/30/25
The program provides reports of aggregated data and committee/workgroup minutes analyzing information.	**Compliance**	The program consistently compiles and maintains aggregated data reports and meeting minutes from committees and workgroups, demonstrating active analysis and ongoing program improvement.
The program conducts quarterly case record reviews. (A summary report of case record reviews, identifying compliance with the CINS/FINS requirements, which is reviewed by management and communicated with staff on a quarterly basis at minimum.)	**Exception**	The agency utilizes a statewide quarterly file review process as part of CQI that is comprised of voluminous (over 200) data points, which is thorough but makes it very difficult for the program to identify trends and areas that require improvement. The discussion of the quarterly case reviews is conducted in the quarterly CQI meeting per the Regional Director, however that is not documented and no summary is provided.
The program reviews incidents, accidents, and grievances at least quarterly.	**Compliance**	The program conducts regular reviews of all incidents, accidents, and grievances at least quarterly, ensuring timely analysis, corrective actions, and preventive measures.
The program reviews customer satisfaction data at least annually.	**Compliance**	Customer satisfaction data is reviewed annually, and feedback is used to enhance service quality and client experience.
The program reviews outcome data at least annually.	**Compliance**	Program outcome data is reviewed annually to assess performance against goals and inform quality improvement efforts.
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	Findings from reviews are consistently evaluated by management and effectively communicated to staff and stakeholders to ensure transparency and alignment.
The program demonstrates program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the provider's Executive Committee on the Board of Directors.	**Compliance**	Program performance is routinely presented to the Board of Directors. All final reports receiving a Limited or Failed rating are submitted to the Executive Committee electronically or by mail, as required.
Evidence shows that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	Documentation reflects that program strengths and weaknesses are identified, corrective actions implemented, and staff are informed and engaged throughout the improvement process.
1.7 - Client Transportation		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.7		Yes 1.06 Client Transportation; 10/25/26
Supervisors complete a weekly review of transport documentation and provide written feedback or coaching when deficiencies are found.	**Compliance**	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.	**Compliance**	The agency maintains an established transportation policy and formal approval process that governs all youth transports, ensuring safety and accountability.
All drivers have an approved driver’s license.	**Compliance**	All approved drivers hold valid driver’s licenses verified by the agency prior to transporting youth.

List of approved drivers eligible to drive client(s) for the agency or approved private vehicle that considers the driver's work performance and history, indicating no inappropriate behavior is likely to occur.	**Compliance**	The agency maintains a current list of approved drivers eligible to transport clients, confirming each driver's satisfactory work performance and history free from inappropriate behavior.
The list of approved drivers are covered under the agency's automobile insurance.	**Compliance**	All approved drivers are covered under the agency's automobile insurance policy, and verification of coverage is maintained on file.
There is documentation of use of a vehicle that notes the name or initials of the driver, date and time, mileage, number of passengers, purpose of travel, and location.	**Compliance**	Vehicle logs consistently record the driver's name or initials, date, time, mileage, number of passengers, travel purpose, and destination, providing complete accountability for all transports.
Signed parental consent is obtained in advance of any single transport.	**Compliance**	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.	**Compliance**	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.	**Compliance**	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.
1.8 - Client Contact Policy		**Satisfactory with Exception/s**
Provider has a written policy and procedure that meets the requirement for Indicator 1.8		No
		Initial findings indicate that the agency did not have a current policy pertaining to client contact. Policy was created and signed by the Regional Director prior to reviewer leaving site.
Additional Comments:		
1.9 - Community Referrals and Outreach Services		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.9		Yes
		1.07 Outreach Services policy was reviewed and approved by the Regional Director on 2/01/2026.
Outreach activities include education about services offered and guidance on accessing those services.	**Compliance**	The program's outreach activities effectively educate the community about available services and provide clear guidance on how to access them.
The program has evidence that provides minutes of the event or other verification of staff participation.	**Compliance**	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.	**Compliance**	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.	**Compliance**	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.	**Compliance**	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.	**Compliance**	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.	**Compliance**	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.	**Compliance**	Copies of all partnership agreements are submitted to the Florida Network as required, ensuring transparency and statewide coordination of services.
Domain Three		
3.2 - Admission Process		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.2		Yes Policy 2.01, Screening and Intake, was last revised on 07/09/25 by the Regional Director, Shelter Services Manager, and the Quality Management Specialist.
A total of ten file(s) were reviewed during this evaluation period. Of these, four were open and six were closed. Among the open file(s),one residential (RES) and three community counseling file(s) were reviewed. Among the closed file(s), four residential (RES) and two community counseling file(s) were reviewed.		
The screening form is completed immediately for all inquiries into shelter placement.	**Compliance**	For all inquiries into shelter placement, screening forms were completed immediately by trained staff, ensuring timely assessment and appropriate service placement.
For Community Counseling Services: The initial screening for eligibility for Community Counseling Services (including screening for eligibility, crisis counseling and information, and referral) occurs within 3 business days of referral by a trained staff member using, at minimum, the Florida Network screening form.	**Compliance**	Initial screenings for Community Counseling Services were completed within three business days of referral by trained staff using the Florida Network screening form. All eligibility, crisis, and referral requirements were met.
Youth and parents/guardians receive the following in writing		
Youth and parents/guardians are provided available service options in writing.	**Compliance**	Youth and parents/guardians were provided written information outlining all available service options, ensuring informed decision-making about participation.
Youth and parents/guardians are provided “Rights and Responsibilities of Youth” in writing.	**Compliance**	Written materials detailing the rights and responsibilities of youth were provided at intake, and documentation confirmed receipt in all reviewed files.
Parents/guardians are provided “Rights and Responsibilities of Parents” and/or parent brochure.	**Compliance**	Parents and guardians were provided the “Rights and Responsibilities of Parents” brochure at intake, and signed acknowledgment forms were present in all records.
The following is also available to the youth and parents/guardians:		
Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication).	**Compliance**	Youth and parents/guardians received written information describing possible outcomes and actions that may occur through involvement with CINS/FINS services, including case staffing, petitions, and adjudications.
Youth and parents/guardians are provided information regarding the programs grievance procedures.	**Compliance**	All youth and parents/guardians were informed of the program’s grievance procedures, and documentation confirmed this information was reviewed and acknowledged.

If the youth and family do NOT participate in services, the reason is documented on the screening form and logged in NetMIS.	**Not Applicable**	All ten files reviewed participated in services.
The intake took place in a setting that allows the client to feel safe and heard.	**Compliance**	Intakes were conducted in private, trauma-informed settings designed to help youth feel safe, respected, and heard throughout the process.
3.3 - NIRVANA (Network Inventory of Risks, Victories, and Needs Assessment)		**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 3.3		Yes
		Policy 2.02, NIRVANA, was last revised on 03/10/26 by the Regional Director, Shelter Services Manager, and the Quality Management Specialist.
For youth in shelter care: NIRVANA Assessment initiated within 72 hours of admission.	**Compliance**	All youth admitted to shelter care had their NIRVANA Assessment initiated within 72 hours of admission, ensuring prompt evaluation and service engagement.
For youth in shelter care: NIRVANA Assessment is completed within seven (7) days from intake.	**Compliance**	All NIRVANA Assessments for shelter youth were completed within seven days of intake, confirming timely completion of assessment requirements.
NIRVANA Assessment is completed within one to two contacts following the initial intake date into services.	**Compliance**	All Community Counseling NIRVANA Assessments were completed within one to two contacts after intake, consistent with Florida Network guidelines.
NIRVANA Assessment is initiated at intake.	**Compliance**	All components of the NIRVANA process initiation were fully compliant and supported by documentation in each file.
NIRVANA Assessment was conducted by a bachelor's or master's degree staff who has completed the Florida Network NIRVANA training and has had Motivational Interviewing (MI).	**Compliance**	All assessments were completed by qualified bachelor's or master's level staff who successfully completed both NIRVANA and Motivational Interviewing training, verified through the staff roster.
All completed NIRVANA assessments are entered electronically into the Florida Network Management Information System (NetMIS) within three (3) business days of service commencement.	**Exception**	Three out of ten files reviewed did not have NIRVANA entered into NetMIS within three business days.
The supervisor's signature is documented on the completed NIRVANA Assessment and/or the chronological note and/or the interview guide that is located in the youths' file within 7 business days.	**Exception**	For four out of ten files reviewed, the supervisor signature predated the assessment print date and review date could not be verified. For two out of ten files, the supervisor signature was missing, and for one out ten files the supervisor signature was missing.
(Shelter only) NIRVANA Self-Assessment Report (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	**Compliance**	For all shelter admissions, the NIRVANA Self-Assessment Report (NSR) was completed within 24 hours, with any exceptions fully documented in NetMIS and the youth's file.
A NIRVANA Post-Assessment is completed at discharge for youth who have a length of stay that is greater than 30 days.	**Compliance**	All youth with stays exceeding 30 days received a completed NIRVANA Post-Assessment at discharge to measure progress and outcomes.
A NIRVANA Re-Assessment is completed every 90 days with the exception of SNAP services.	**Exception**	One out of ten files had a NIRVANA Re-Assessment completed after 90 days.
All files must have the interview guide and/or printed NIRVANA.	**Compliance**	Each file reviewed contained a completed interview guide and/or a printed copy of the NIRVANA Assessment, demonstrating proper documentation and retention.
3.4 - Case Management, Counseling & Non-Residential Services Policy		**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 3.4		No
		Policy 2.04, Case Management and Service Delivery, and policy 2.05, Counseling Services, were last revised on 03/10/26 by the Regional Director, Shelter Services Manager, and the

Each client is assigned a Counselor.	**Compliance**	Each client was assigned a qualified counselor responsible for coordinating services and maintaining consistent therapeutic engagement.
The following is also available to the youth and parents/guardians:		
In the Shelter Program: Counseling services are provided to each client at least once per week, for the first 12 weeks of services, by a licensed mental health professional or non-licensed staff with clinical experience or has completed the required clinical training working under the direct supervision of a licensed staff member.	**Exception**	Two out of five residential files reviewed did not have counseling services provided at least once per week.
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. *(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)*	**Exception**	Two out of five community counseling files reviewed did not have counseling services provided at least once per week.
The reason(s) why a required weekly session could not be provided is documented in the youth's file and in NetMIS.	**Exception**	Four out of ten files reviewed did not have the reason a weekly session could not be provided documented in both the youth's file and in NetMIS.
If case management needs extend beyond the counselor's role, a case manager is assigned.	**Not Applicable**	Counselor serves case management roles as well.
Case Manager establishes appropriate referrals to services.	**Not Applicable**	The randomly selected sample reviewed during this review included no cases that required referrals.
All counseling and case management sessions are documented in the youth's file and NetMIS, including the reason for missed sessions.	**Exception**	Five out of ten files reviewed did not have all sessions documented in both the youth's file and in NetMIS.
If mental health or substance abuse needs, outside of the program's capacity, are identified appropriate referrals are made and documented.	**Not Applicable**	The random sample reviewed during this review included no cases that required referrals.
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.	**Not Applicable**	None of the youth files reviewed were receiving respite services.
Clients that do not receive services for 30 days or more have their case closed.	**Not Applicable**	All youth files reviewed showed evidence of no lapse in services.
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.	**Exception**	Supervision was not offered on a consistent weekly basis. There were no documented reasons as to why supervision was not conducted. The forms for supervision were not consistently completed and one counselor had no supervision sessions that documentation could be provided for.
3.5 - Adjudication Services: Case Staffing		**Not Applicable**
		No
		Policy 2.06, Adjudication/ Petition Process, was last revised on 03/10/26 by Regional Director,

Provider has a written policy and procedure that meets the requirement for Indicator 3.5		Shelter Services Manager, and the Quality Management Specialist. The agency policy did not include the goals of the Case Staffing Committee. Regional Director was notified and verbally confirmed it will be added.
A case staffing committee meeting is scheduled when one of the following occur (at minimum): 1. the youth/family is not in agreement with services or treatment; 2. the youth/family will not participate in the services selected, 3. the youth's referring problem has not shown substantial improvement within six weeks of initiating counseling. 4. the program receives a written request from the parent/guardian or any other member of the committee	**Not Applicable**	The random sample reviewed during this review included no case staffing cases.
Each case staffing must be recorded in NetMIS within the case, noting the date it occurred.	**Not Applicable**	The random sample reviewed during this review included no case staffing cases.
The case staffing is convened within 7 days (excluding weekends and legal holidays) of the parent/guardian request.	**Not Applicable**	The random sample reviewed during this review included no case staffing cases.
Notification to the committee is sent no less than 5 working days prior to the staffing date.	**Not Applicable**	The random sample reviewed during this review included no case staffing cases.
A written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations.	**Not Applicable**	The random sample reviewed during this review included no case staffing cases.
As a result of the case staffing committee meeting, the youth and family are provided a new or revised plan for services.	**Not Applicable**	The random sample reviewed during this review included no case staffing cases.
At a minimum, the case staffing is attended by:		
Local school district representative	**Not Applicable**	The random sample reviewed during this review included no case staffing cases.
DJJ rep. or CINS/FINS provider	**Not Applicable**	The random sample reviewed during this review included no case staffing cases.
Other members may include:		
State Attorney's Office	**Not Applicable**	The random sample reviewed during this review included no case staffing cases.
Mental health representative	**Not Applicable**	The random sample reviewed during this review included no case staffing cases.
Substance abuse representative	**Not Applicable**	The random sample reviewed during this review included no case staffing cases.
Law enforcement representative	**Not Applicable**	The random sample reviewed during this review included no case staffing cases.
DCF representative	**Not Applicable**	The random sample reviewed during this review included no case staffing cases.
Others requested by youth/family	**Not Applicable**	The random sample reviewed during this review included no case staffing cases.
The program has an established case staffing committee and has regular communication with committee members.	**Not Applicable**	The random sample reviewed during this review included no case staffing cases.
The program has an established case staffing committee, and has regular communication with committee members.	**Not Applicable**	The random sample reviewed during this review included no case staffing cases.
3.6 - Adjudication Services: CINS Petition Process		**Not Applicable**
Provider has a written policy and procedure that meets the requirement for Indicator 3.6		Yes Policy 2.06, Adjudication/ Petition Process, was last revised on 03/10/26 by Regional Director, Shelter Services Manager, and the Quality Management Specialist.
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 random sample reviewed during this review included no case staffing cases.

The Case Manager/Counselor completes a review summary prior to the court hearing for a youth.	**Not Applicable**	The random sample reviewed during this review included no case staffing cases.
3.7 - Service Plan		**Satisfactory with Exception/s**
Provider has a written policy and procedure that meets the requirement for Indicator 3.7		Yes
		Policy 2.03, Case/ Service Plan was last revised on 03/10/26, by Regional Director and Shelter Services Manager.
A Case/Service Plan is developed within seven (7) working days of the youth's intake in the shelter program.	**Compliance**	The Case/Service Plan is completed within seven working days of intake, ensuring timely service initiation.
A Case/Service Plan is developed within one contact following the completion of the NIRVANA in the community counseling program.	**Compliance**	The Case/Service Plan is completed within one contact of the NIRVANA, demonstrating prompt follow-up and coordination.
The plan is developed on a local provider approved form or through NETMIS based on information gathered during initial screening, intake, and NIRVANA.	**Compliance**	The Case/Service Plan is completed using approved provider forms or NETMIS, based on information from screening, intake, and NIRVANA.
Youth and parents/guardians receive the following in writing		
The Case/Service Plan reflects the individualized and prioritized needs and goals identified during the assessment process, including relevant domains from the NIRVANA.	**Compliance**	Individualized and prioritized needs and goals are clearly identified based on the assessment process, incorporating all relevant domains from the NIRVANA.
Each plan clearly documents the type of service(s) to be provided, the frequency, and the location of services.	**Compliance**	Each plan clearly outlines the type, frequency, and location of services to ensure structured and consistent service delivery.
The plan identifies the person(s) responsible for implementing each service or action step.	**Compliance**	The plan specifies the person(s) responsible for implementing each service or action step, promoting accountability and effective follow-through.
The target date(s) for completion are documented in the service plan for each identified goal.	**Compliance**	Each plan includes clear target date(s) for goal completion, supporting timely progress monitoring and accountability.
The actual completion date(s) are documented in the service plan for each identified goal.	**Compliance**	Actual completion date(s) are consistently recorded, demonstrating effective tracking of service delivery and goal attainment.
The signature of the youth is documented in the service plan.	**Exception**	One out of ten files reviewed did not have the youth signature.
The signature of the parent/guardian is documented in the service plan.	**Exception**	Four out of ten files reviewed did not have a parent signature.
If unavailable, the absence is documented with a reason on the plan.	**Exception**	One out of four files reviewed that had a missing parent signature did not have a documented reason for the absence.
The signature of the counselor is documented in the service plan.	**Compliance**	Counselor signatures are included on all plans, verifying professional oversight and approval of service goals and actions.
The signature of the LMHP reviewing the plan is signed within seven (7) days of plan completion.	**Exception**	Four out of ten files reviewed did not have a supervisor signature within seven days of plan completion.
The date of plan initiation is clearly indicated.	**Compliance**	The date of plan initiation is clearly documented, ensuring clarity on when services and interventions began.

The Case/Service Plan is formally reviewed and revised in collaboration with the youth and parent(s)/guardian(s):		
At, 30 Days, following plan initiation.	**Exception**	One out of ten files reviewed did not have a 30 day review completed on time.
At, 60 Days, following plan initiation.	**Exception**	One out of ten files reviewed did not have a 60 day review completed on time.
At, 90 Days, following plan initiation.	**Exception**	One out of ten files reviewed did not have a 90 day review completed on time.
For court ordered youth, every six (6) months thereafter, or more frequently as needed to reflect changes in progress, needs, or service delivery.	**Not Applicable**	None of the cases reviewed were court ordered youth.
3.8 - Youth Records		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.8		Yes Policy 2.07, Youth Records, was last revised on 03/10/26 by the Regional Director, Shelter Services Manager, and Quality Management Specialist.
All records are marked “confidential”.	**Compliance**	All youth records were clearly marked “Confidential,” ensuring proper identification and adherence to privacy requirements.
All records are kept in a secure room or locked in a file cabinet that is marked “confidential” and only accessible by staff.	**Compliance**	All records were stored securely in locked file cabinets or designated confidential rooms accessible only to authorized staff.
When in transport, all records are locked in an opaque container marked “confidential”.	**Compliance**	When transported, all records were placed in locked, opaque containers marked “Confidential,” maintaining privacy and data security.
All records are maintained in a neat and orderly manner.	**Compliance**	Records were consistently maintained in a neat, orderly, and professional manner, ensuring quick access and review readiness.
SHELTER FILES 1. Table of Contents that outlines documents in each section 2. Screening 3. Informed Consent 4. Photograph of the youth 5. Shelter Intake Form 6. Suicide Assessment (if needed) 7. NIRVANA Self Report (NSR) 8. NIRVANA full Assessment 9. Plan of Service 10. Chronological Notes 11. Medication Inventory Form 12. Approved contact list 13. Copies of referrals made (if needed) 14. Discharge summary once case is closed	**Compliance**	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.

COMMUNITY COUNSELING FILES 1. Table of Contents that outlines documents in each section 2. Screening 3. Informed Consent 4. Community Counseling Intake Form 5. Suicide Assessment (if needed) 6. NIRVANA full Assessment 7. Plan of Service 8. Chronological case notes 9. Copies of referrals made (if needed) 10. Discharge summary once the case is closed	**Compliance**	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.
If records are kept electronically, the records are maintained securely and can be made immediately available upon request for audit purposes.	**Not Applicable**	The program does not keep records electronically.
Records are retained for five years after the termination date of the contract that is funding the youth's service.	**Compliance**	Records were retained in compliance with policy for a minimum of five years following the termination date of the contract funding the youth's services.
3.10 - Discharge and Follow Up		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.10		Policy 2.08, Discharge and Aftercare, was last reviewed on 03/10/26 by Regional Director and Shelter Services Manager.
30 day follow-ups are provided post discharge for all youth served.	**Compliance**	Follow-up contacts were completed within 30 days post-discharge, with documentation confirming continued client stability and connection to recommended services.
60 day follow-ups are provided post discharge for all youth served.	**Compliance**	Follow-up contacts were also completed within 60 days post-discharge, ensuring ongoing support and successful transition for youth and families.
Each file contains a discharge summary that describes the reason for termination.	**Compliance**	Discharge summaries clearly described the reason for termination, confirming appropriate closure of services and alignment with client progress.
Each file contains a discharge summary that outlines the events of the case, services provided, progress of the youth and family, and recommendations for future treatment or services.	**Compliance**	Each discharge summary outlined key case events, services provided, and measurable progress made by the youth and family throughout service delivery.
Each file contains a discharge summary that describes the living arrangements of the child at termination. If the child is not returned to the family at termination, the discharge summary must contain the reasons for the alternative placement, plans for the child's living arrangement, and interim objectives set that will accomplish an eventual return, if possible and when appropriate.	**Compliance**	All discharge summaries documented the youth's living arrangements at termination. For youth not returning home, the file included the reasons for alternative placement, plans for ongoing stability, and goals supporting future reunification when appropriate.
Each file contains a discharge summary that outlines the aftercare recommendations and the arrangements for case follow-up.	**Compliance**	Discharge summaries detailed aftercare recommendations and follow-up arrangements, ensuring continuity of care and resource connection beyond program exit.

Each file contains a NIRVANA Post Assessment.	**Compliance**	Each applicable file contained a completed NIRVANA Post-Assessment, documenting the youth's progress and outcomes at discharge.
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.	**Not Applicable**	None of the files reviewed were referred by truancy court.
Domain Four		
4.0 - SNAP® Under 12		**Satisfactory with Exception/s**
Provider has a written policy and procedure that meets the requirement for Indicator 4.0		Yes Policy # 2.09 SNAP was revised/approved by the Regional Director on 10/25/2025.
Youth are screened to determine eligibility of services using the Florida Network Youth Screening Form.	**Compliance**	Youth are screened for service eligibility using the Florida Network Youth Screening Form prior to initiation.
A total of eight SNAP® Under 12 file(s) were reviewed during this evaluation period. Of these, four were open and four were closed.		
The following documentation is required BEFORE initiating SNAP® services and located within the Youth File:		
SNAP® Client File Checklist	**Compliance**	The SNAP® Client File Checklist is completed and on file before services begin.
Florida Network CINS/FINS Youth Screening Form	**Compliance**	The Florida Network CINS/FINS Youth Screening Form is present and completed prior to service initiation.
SNAP® Brief Intake Screening Checklist (BISC)	**Compliance**	The SNAP® Brief Intake Screening Checklist (BISC) is completed and filed before service initiation.
The file contains the Florida Network Community Counseling Intake Form	**Compliance**	The Florida Network Community Counseling Intake Form is included in the youth file prior to services.
The NIRVANA Assessment	**Compliance**	The NIRVANA® Assessment is completed and filed before services begin.
The Reinforcement Trap Cycle	**Compliance**	The Reinforcement Trap Cycle is completed and included in the youth file prior to services.
The SNAP® Parenting Goal Sheet	**Compliance**	The SNAP® Parenting Goal Sheet is completed and on file prior to services.
The Child Way To Go Goal Sheet	**Compliance**	The Child Way To Go Goal Sheet is completed and on file prior to services.
The SNAP Child Screening Interview	**Compliance**	The SNAP® Child Screening Interview is completed and documented before services begin.
Consent to Treatment and Participation in Research Form	**Compliance**	Consent to Treatment and Participation in Research is signed and on file prior to service initiation.
Tool of Parenting Self-Efficacy (TOPSE) – pre-assessment	**Compliance**	The Tool of Parenting Self-Efficacy (TOPSE) pre-assessment is completed and filed prior to services.
Child Behavior Checklist (CBCL) – caregiver	**Compliance**	The Child Behavior Checklist (CBCL) caregiver form is completed and filed prior to services.
Session Preparation and Delivery Activities		
Staff conduct weekly check-in calls with youth and caregivers.	**Compliance**	Staff complete and document weekly check-in calls with youth and caregivers as scheduled.
Weekly attendance is documented for youth.	**Compliance**	Weekly youth attendance is documented on the Youth Attendance Chart.
Weekly attendance is documented for caregiver.	**Compliance**	Weekly caregiver attendance is documented on the Caregiver Attendance Chart.

Weekly attendance is documented for siblings.	**Compliance**	Weekly sibling attendance is documented on the Sibling Attendance Chart.
If needed, make-up sessions and the Adherence Contact Notes are completed.	**Compliance**	Make-up sessions and Adherence Contact Notes are completed and documented when needed.
Each GROUP CYCLE MUST include the following documentation:		
Weekly Feedback Questionnaires	**Compliance**	Weekly Feedback Questionnaires are completed and filed for each session.
Weekly Youth Evaluation Forms	**Compliance**	Weekly Youth Evaluation Forms are completed and filed.
Weekly Caregiver Evaluation Forms	**Compliance**	Weekly Caregiver Evaluation Forms are completed and filed.
SNAP® Debrief Checklist completed after each session and uploaded within three (3) business days	**Exception**	Although staff internally tracks weekly debriefing, this requirement was not uploaded weekly as required.
Discharge and Post-Assessment Documents & Required Discharge Documentation includes:		
SNAP® Group Evaluation Forms (Week 13 – youth and caregiver)	**Compliance**	Week 13 SNAP® Group Evaluation Forms (youth and caregiver) are completed and filed.
Post-TOPSE entered into NetMIS (in file from NetMIS)	**Compliance**	Post-TOPSE results are entered into NetMIS and filed from NetMIS.
Post Child Behavior Checklist (CBCL) – (entered into ASEBA-Web in Youth File)	**Compliance**	Post-CBCL results are entered into ASEBA-Web and filed in the youth record.
Post-NIRVANA entered into NetMIS (youth file from NetMIS)	**Compliance**	Post-NIRVANA results are entered into NetMIS and filed from NetMIS.
Discharge and Post-Assessment Documents & Required Discharge Documentation includes:		
Discharges are completed within 30 days of group completion	**Compliance**	Discharges are completed within thirty (30) days of group completion.
If a post-assessment is not completed, there are at least three (3) DOCUMENTED attempts to collect each post-assessment.	**Not Applicable**	All post assessments were completed as required.
SNAP® Discharge Report is filed	**Compliance**	The SNAP® Discharge Report is completed and filed.
SNAP Discharge Report includes: Reason for discharge	**Compliance**	The discharge report includes the reason for discharge.
Summary of services delivered and goal progress	**Compliance**	The discharge report summarizes services delivered and progress toward goals.
Pre/post assessment outcomes (if available)	**Compliance**	The discharge report summarizes pre/post assessment outcomes when available.
Aftercare referrals or follow-up recommendations	**Compliance**	The discharge report documents aftercare referrals and follow-up recommendations.
Discharge and Post-Assessment Documents & Required Discharge Documentation includes:		
30-day and 60-day follow-ups were completed using the SNAP® Contact Note format.	**Compliance**	30-day and 60-day post-discharge follow-ups are completed using the SNAP® Contact Note format.
Follow-up records were entered into NetMIS within three (3) business days of completion.	**Compliance**	Follow-up records are entered into NetMIS within three (3) business days of completion.
4.1 - SNAP® Fidelity Monitoring		**Satisfactory**
		Yes
		2.09 Stop Now and Plan (SNAP), reviewed by Regional Director on 10/25/2025 and

Provider has a written policy and procedure that meets the requirement for Indicator 4.1		updated/approved by Regional Director on 3/18/2026. The SNAP Fidelity policy initially did not include SNAP Youth Justice, however the practice was clearly in place (reviewed 9 sessions in current cycle that began on 2/3/26 and 13 sessions that began on 12/3 in NetMIS an found Fidelity Monitoring was conducted to assess the facilitator , as required.
4.2 - SNAP® for Youth		**Not Applicable**
Provider has a written policy and procedure that meets the requirement for Indicator 4.2		**The agency is not contracted to provide SNAP for Youth services.**
Intake Documents Include the following (Before youth begins SNAP® group participation:		
SNAP® Youth Client File Checklist	**Not Applicable**	The agency is not contracted to provide SNAP for Youth services.
Florida Network Youth Screening Form	**Not Applicable**	The agency is not contracted to provide SNAP for Youth services.
Florida Network Community Counseling Intake Form	**Not Applicable**	The agency is not contracted to provide SNAP for Youth services.
SNAP Youth Intake Brief Screening Checklist (Teacher or Caregiver version)	**Not Applicable**	The agency is not contracted to provide SNAP for Youth services.
NIRVANA® Assessment	**Not Applicable**	The agency is not contracted to provide SNAP for Youth services.
Consent to Treatment and Participation in Research Form	**Not Applicable**	The agency is not contracted to provide SNAP for Youth services.
SNAP® for Youth Orientation Document	**Not Applicable**	The agency is not contracted to provide SNAP for Youth services.
Youth Goal Sheet	**Not Applicable**	The agency is not contracted to provide SNAP for Youth services.
How I Think Questionnaire (HIT)	**Not Applicable**	The agency is not contracted to provide SNAP for Youth services.
Social Skills Improvement System (SSIS) – Student Form	**Not Applicable**	The agency is not contracted to provide SNAP for Youth services.
Social Skills Improvement System (SSIS) – Teacher/Adult Form	**Not Applicable**	The agency is not contracted to provide SNAP for Youth services.
Intake Data Entry Compliance: All NetMIS data entries related to intake must be completed within three (3) business days.	**Not Applicable**	The agency is not contracted to provide SNAP for Youth services.
Weekly Group Compliance: Staff must conduct a check-in call with each youth using the SNAP® Client Group Reminder Log.	**Not Applicable**	The agency is not contracted to provide SNAP for Youth services.
During Sessions: Record weekly attendance in the Youth Attendance Log.	**Not Applicable**	The agency is not contracted to provide SNAP for Youth services.
For Make-up Sessions: Client Contact Note (minimum 45 min) and Fidelity Adherence Checklist are completed.	**Not Applicable**	The agency is not contracted to provide SNAP for Youth services.
For Make-up Sessions: Client Contact Note and Fidelity Adherence Checklist are uploaded and entered into NetMIS within three (3) business days of the make-up date (NetMIS).	**Not Applicable**	The agency is not contracted to provide SNAP for Youth services.
Post-Discharge Follow-up		
The 30-day Post-Discharge NETMIS Follow-up was completed as required.	**Not Applicable**	The agency is not contracted to provide SNAP for Youth services.
The 60-day Post-Discharge NETMIS Follow-up was completed as required.	**Not Applicable**	The agency is not contracted to provide SNAP for Youth services.
Follow-ups are documented using the SNAP Contact Note.	**Not Applicable**	The agency is not contracted to provide SNAP for Youth services.

The 30-day follow-up is entered into NetMIS within three (3) business days of each follow-up completion.	**Not Applicable**	The agency is not contracted to provide SNAP for Youth services.
The 60-day follow-up is entered into NetMIS within three (3) business days of each follow-up completion.	**Not Applicable**	The agency is not contracted to provide SNAP for Youth services.
4.3 - SNAP® Youth Justice		**Satisfactory with Exception/s**
Provider has a written policy and procedure that meets the requirement for Indicator 4.3		Yes
		Policy 2.09, Stop Now and Plan, last revised on 10/25/26 by Regional Director, Shelter Services Manager, and Quality Management Specialist. Upon initial review the policy was missing the following language: present behavioral needs being an admission criteria, curriculum modifications and group being scheduled to avoid school conflicts. The policy was updated by the Regional Director on 3/18/2026.
A total of eight SNAP® Youth Justice file(s) were reviewed during this evaluation period. Of these, two were open and six were closed.		
Pre-Service Documentation, prior to beginning group services, must be in youth files and includes:		
SNAP® Youth Client File Checklist	**Compliance**	All required SNAP® Youth Client File Checklists were completed prior to service initiation.
Florida Network Youth Screening Form	**Compliance**	All required Florida Network Youth Screening Forms were completed prior to service initiation.
Florida Network Community Counseling Intake Form	**Compliance**	Florida Network Community Counseling Intake Forms were properly documented prior to beginning group services.
NIRVANA® Assessment	**Compliance**	NIRVANA® Assessments were completed promptly and filed prior to service initiation.
Consent to Treatment and Participation in Research Form	**Compliance**	Consent to Treatment and Participation in Research Forms were signed and dated before youth participation.
SNAP® Orientation Document	**Compliance**	SNAP® Orientation Documents were completed and included in the file before the first session.
Youth Goal Sheet	**Compliance**	Youth Goal Sheets were developed collaboratively and finalized prior to service delivery.
How I Think Questionnaire (HIT)	**Compliance**	How I Think Questionnaires (HIT) were administered within the required pre-service timeframe.
Social Skills Improvement System (SSIS) – Student Form	**Compliance**	Social Skills Improvement System (SSIS) – Student Forms were completed prior to program participation.
Social Skills Improvement System (SSIS) – Teacher/Adult Form	**Exception**	One out of eight client files reviewed did not have the Social Skills Improvement System (SSIS) – Teacher/Adult Form.
Group Delivery and Fidelity: A check-in call is conducted 24-72 hours prior to each session and documented.	**Compliance**	Pre-session check-in calls were completed and documented 24–72 hours prior to each session.
Group Delivery and Fidelity: There is evidence that the youth attended a total of thirteen (13) sessions.	**Compliance**	Youth successfully participated in the full thirteen (13) SNAP® sessions as scheduled.
Post-Session & Evaluation Activities: Weekly group attendance and any issues are reported to each youth's JPO and the local CPO via email correspondence.	**Exception**	One out of eight client files reviewed did not have attendance reported to JPO/CPO on a weekly basis.
Post-Session & Evaluation Activities: Attendance Logs are maintained for each session.	**Compliance**	Attendance logs were accurately maintained and available for all program sessions.

Discharge Requirements		
Discharge summary completed for youth, regardless of completion status.	Compliance	Discharge summaries were completed for all youth, regardless of program completion status.
NIRVANA completed at Discharge	Compliance	NIRVANA® assessments were completed at discharge and filed appropriately.
At least three (3) documented attempts must be made to collect post-assessment data.	Not Applicable	No documented attempts were required due to post-assessment data was present in all applicable files reviewed.
Discharge Report Includes the Following:		
Reason for discharge	Compliance	Each discharge report clearly identifies the youth's reason for discharge.
Summary of services and goal progress	Compliance	Discharge reports include a comprehensive summary of services provided and progress toward goals.
Summary of pre/post test changes, if available	Exception	Five out of eight client files reviewed did not have a summary of pre and post test changes in the discharge report.
Aftercare recommendations or referrals	Compliance	Aftercare recommendations and referrals are documented to support ongoing success.
Post-Discharge Follow-Up Includes the following:		
The 30-day Post-Discharge Follow-up was completed.	Compliance	30-day post-discharge follow-ups were completed and documented in applicable youth files.
The 60-day Post-Discharge Follow-up was completed.	Compliance	60-day post-discharge follow-ups were completed and documented in applicable youth files.
Follow-ups are documented using the SNAP Contact Note Format.	Compliance	All follow-ups were documented using the SNAP® Contact Note format.
4.5 - SNAP® for Schools and Communities		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.5		Yes 2.09 Stop Now and Plan (SNAP) reviewed and approved by Regional Director on 10/25/2025.
There is evidence the Measure of Classroom Environment (MoCE)-Pre-session is completed before beginning SNAP® for Schools and Communities.	Compliance	The Measure of Classroom Environment (MoCE) pre-session assessment is completed prior to beginning the SNAP® for Schools and Communities program.
A Fidelity Adherence Checklist completed per classroom was verified in the file.	Compliance	A Fidelity Adherence Checklist is completed for each classroom and verified in the file as required.
Each group session is entered into NetMIS within 3 business days of the session.	Compliance	Each group session is entered into NetMIS within three (3) business days of completion.
There is evidence of the SNAP® for Schools & Communities Feedback Form completed by the supervisory adult responsible at the final group.	Compliance	The SNAP® for Schools and Communities Feedback Form is completed by the supervising adult responsible at the final group session.
Domain Five		
5.0 - Shelter Program Services		**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 5.0		Yes 3.01 Shelter Environment approved 03/26 by Regional Director, Shelter Manager, Quality Manager

Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal.	**Compliance**	Youth are engaged in meaningful, structured activities seven days a week during awake hours, minimizing idle time and promoting positive development.
At minimum one hour of physical activity is provided daily.	**Compliance**	A minimum of one hour of physical activity is provided to youth each day as part of the daily schedule.
Youth are provided the opportunity to participate in a variety of faith-based activities aligned with their preference or spiritual beliefs. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities.	**Compliance**	Youth are offered opportunities to participate in faith-based activities aligned with their personal beliefs, and non-punitive structured activities are provided for those who choose not to participate.
Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read.	**Compliance**	Daily programming includes scheduled time for homework completion, access to age-appropriate reading materials, and opportunities for quiet reading and learning.
Daily programming schedule is publicly posted and accessible to both staff and youth.	**Compliance**	The daily programming schedule is clearly posted in a public area and accessible to both staff and youth.
Psychoeducational Groups are conducted a minimum of five days per week using a structured group process model. There is a clear group leader or facilitator identified, and documentation includes the date/time of group, list of participants, length of group, and the topic.	**Exception**	Sample reviewed: October 2025- current. Groups were not consistently provided 5 times per week. Most weeks had 3 or 4 groups documented, no weeks had any less than 2 groups.
Formal and accessible grievance procedures for youth, including available grievance forms and a locked box, are accessible to youth in a common area.	**Compliance**	Formal and accessible grievance procedures are in place for youth, including the availability of grievance forms and a locked grievance box located in a common area.
Grievance boxes are checked at least once daily, excluding weekends and holidays) by a member of management or a designated supervisor. Each check is logged in the program's daily logbook, including the date, time, and name of the person conducting the check.	**Exception**	Hope House is missing the following grievance box checked dates: December 1-3, 2025 and February 1-3, 2026. Currie House is missing the following grievance box check dates: September 4, 10, 25, 2025, October 7,10,14,20,23, 2025, November 7, 2025, December 2,5,8,10-12,16, 2025, January 5-7, 22,27, 2026, and February 5,11,16,19, 2026.
Only the Program Director/Supervisor has access to and manages grievances unless it is toward themselves (which is escalated to higher leadership).	**Compliance**	Only the Program Director or Supervisor has access to and manages submitted grievances, unless the grievance concerns them, in which case it is escalated to higher leadership.
All grievances are resolved and documented by the Program Director within 72 hours. If this does NOT occur within the 72-hour period, there is sufficient documentation explaining the cause of the delay in resolution.	**Exception**	One form did not have a completion date next to the signature.
Grievances are maintained on file for a minimum of one (1) year.	**Exception**	Currie House was only able to provide March 2026 back to December 2025. Hope House maintained grievance forms going back at least one year.
Additional Comments:		
5.1 Shelter Environment		**Satisfactory with Exception/s**
Provider has a written policy and procedure that meets the requirement for Indicator 5.1		Yes 3.01 Shelter Environment approved 03/26 by Regional Director, Shelter Manager, Quality Manager
The facility is clean, neat, and well-maintained.	**Compliance**	The facility is consistently clean, neat, and well-maintained throughout all areas.

Furnishings shall be in good repair and maintained as needed.	**Compliance**	All furnishings are in good repair and suitable for use.
The program is free of insect infestation.	**Exception**	Flies were observed swarming around a light in the entry way of Hope House. The program submitted a work order for pest control the same day.
All bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, mildew and in good working order.	**Compliance**	Bathrooms and shower areas are clean, fully functional, odor-free, and maintained to high sanitary standards.
There is no graffiti on walls, doors, or windows.	**Compliance**	No graffiti or defacement is present on any walls, doors, or windows.
Lighting is adequate for tasks performed there.	**Exception**	A light fixture in the bathroom of Bedroom #3 at Hope House was noted to be broken during the initial walk through. The program submitted a work order to have the light repaired the same day.
Exterior areas are free of debris.	**Compliance**	Exterior areas are clear of debris and well-kept.
Grounds are free of hazards.	**Compliance**	Grounds are regularly inspected and free of hazards.
Dumpster and garbage can(s) are covered.	**Compliance**	Dumpsters and garbage cans are securely covered and properly maintained.
All doors are secure.	**Compliance**	All facility doors are secure and functioning properly.
In and out access is limited to staff members and key control is in compliance.	**Compliance**	Access to and from the facility is restricted to authorized staff, and key control procedures are followed in compliance with policy.
All agency and staff vehicles are locked. All agency vehicles are equipped with major safety equipment including first aid kit (with current, non-expired items that are replaced regularly), a fire extinguisher, a flashlight, a glass breaker, and seat belt cutter.	**Exception**	One staff vehicle was found to be unlocked at Hope House. Staff reported that she had recently moved the car and forgot to lock it.
Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted.	**Compliance**	Required postings—including evacuation maps, client rules, grievance procedures, abuse hotline numbers, and DJJ incident reporting information—are clearly displayed and accessible.
Agency has a current DCF Child Care License which is displayed in the facility.	**Compliance**	The current DCF Child Care License is valid and visibly posted in the facility.
Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects (e.g. cords, rope, metal shower rings).	**Compliance**	Interior spaces are free from contraband or hazardous unauthorized materials, including metal or foreign objects.
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.	**Exception**	Weekly inventory is missing weeks of January 3-9, 10-16, 24-29; and February 1-6, 14-27.
Material Safety Data Sheets (MSDS) are maintained on each chemical item.	**Compliance**	Material Safety Data Sheets (MSDS) are maintained and accessible for every approved chemical.

Washer/dryer are operational & general area/lint collectors are cleaned after ever load.	**Compliance**	Washers and dryers are operational, and lint collectors are cleaned after each use.
Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket.	**Compliance**	Each youth is provided with an individual bed, clean mattress, pillow, and sufficient linens and blankets.
Youth have a safe, lockable place to keep personal belongings, if requested.	**Compliance**	Youth have access to a secure, lockable space for personal belongings upon request.
Fire Safety and Health Hazards		
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.	**Compliance**	The annual fire inspection has been completed, and the facility meets all fire marshal and local code requirements.
Agency completes at least one fire drill on each shift monthly and demonstrates they are within 2 minutes or less.	**Exception**	2nd shift is missing the November fire drill for both Currie House and Hope House and Hope House is missing the 2nd shift fire drill for February . Hope House had 10 out 19 fire drills longer than a 2 minute duration.
Completes 1 mock emergency drill per shift quarterly, at a minimum.	**Exception**	Mock drills for September-March for Hope House and Currie House were reviewed. Currie House was found to be missing one 3rd-shift drill in Quarter 1 and one 1st and one 2nd shift drill in Quarter 2. Hope House was found be missing one 2nd shift drill in Quarter 2 and one 3rd shift drill in Quarter 1.
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.	**Compliance**	All fire safety equipment, including extinguishers, sprinklers, alarms, kitchen hood systems, and vehicle extinguishers, have current inspection tags and is easily accessible in case of emergency.
The agency has a current Satisfactory Residential Group Care inspection report from the Department of Health.	**Compliance**	The facility maintains a current, satisfactory Residential Group Care inspection report from the Department of Health.
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.	**Compliance**	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.	**Exception**	At Currie House, cold and dry food items are properly labeled, dated, and stored; pantry and storage areas are clean and organized. At Hope House open dry food items were not dated.
Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.	**Compliance**	Refrigerators and freezers are clean, maintain required temperatures, and all appliances are operational and sanitary.
Additional Comments:		

5.2 - Shelter Search Policy	**Satisfactory with Exception/s**
Provider has a written policy and procedure that meets the requirement for Indicator 5.2	Yes
	3.01 Shelter Environment approved 03/26 by Regional Director, Shelter Manager, Quality Manager

Each youth is searched via a fully charged, hand-held metal detector wand from head to toe, back to front, each time they return to the shelter.	**Compliance**	Each youth is searched thoroughly using a fully charged hand-held metal detector wand from head to toe and back to front upon every return to the shelter, as observed during the review.
Shelter staff conduct searches of outdoor recreational areas prior to youth using the area.	**Compliance**	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.	**Exception**	The Shelter Manager reported that random searches are conducted frequently, however they were not noted in the logbook for verification.
Additional Comments: Youth were observed being searched with hand-held metal detector wand after return from a field trip. Youth were in the Intake/YCS office waiting in line for their turn. All youth were asked to take their socks and shoes off, YCS looked into each youth's shoes. Youth were asked to turn out their pockets, hold out their arms and separate their feet. YCS were observed moving the fully charged wand from head to toe and front to back for each youth. YCS were observed wanding the hoods of youth wearing a hoodie.		

5.3 - Logbook Requirements		**Satisfactory with Exception/s**
Provider has a written policy and procedure that meets the requirement for Indicator 5.3		Yes 3.04 Logbook reviewed and approved by Regional Director, Shelter Manager, and Quality Manager on 03/26
Data sources Reviewed	**Dates Reviewed**	**Logbook Format**
Electronic Logbook, Interview with Shelter Manager, Karen	09/07-20/2025; 10/04-15/2025; 11/19-12/3/2025; 01/15-29/2026; 02/05-02/19/2026; 03/01-15/2026	Electronic
The program has a process in place to document daily activities, events, and other major occurrences.	**Compliance**	The program maintains a consistent process to document daily activities, events, and major occurrences.
Safety and security issues that could impact the youth and/or program are highlighted.	**Compliance**	Safety and security issues that may impact the youth and/or program are clearly identified and highlighted.
All entries are brief and legibly written in ink for paper logbooks.	**Not Applicable**	The programs utilize an electronic logbook.
All entries include: a. Time of incident/activity/event b. Names of youth and staff involved c. Brief statement providing pertinent information d. Signature of person making the entry	**Compliance**	All entries include the time of the incident or activity, names of youth and staff involved, a brief statement of pertinent information, and the signature of the person making the entry.
All recording errors are struck through with a clear line with staff initial and date.	**Compliance**	Recording errors are corrected by striking through with a single line and including the staff's initials and date.
The use of white-out is prohibited and all entries are made in ink with no erasures or white out areas for paper logbooks.	**Not Applicable**	The programs utilize an electronic logbook.
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.	**Exception**	The Shelter Counselors do not document their review of the logbook.
All direct care staff reviews the logbook at the beginning of each shift for the previous two shifts (at minimum) and include the dates reviewed, which is evidenced by the date and their signature at time of entry.	**Compliance**	All direct care staff review the logbook at the start of each shift for at least the previous two shifts and document the review with dates and signatures.

Program director or designee reviews the facility logbook(s) every week and makes a note chronologically indicating dates reviewed and if any corrections, recommendations and follow-up is required, which is evidenced by the date and their signature at time of entry.	**Exception**	The Shelter Manager does not consistently review the logbook each week.
Supervision and resident counts are documented.	**Compliance**	Supervision and resident counts are consistently documented.
Visitation and home visits are documented.	**Compliance**	Visitation and home visits are clearly documented.
Additional Comments:		
5.4 - Staffing Standards and Enhanced Supervision		**Satisfactory with Exception/s**
Provider has a written policy and procedure that meets the requirement for Indicator 5.4		Yes 3.06 Staffing and Youth Supervision reviewed by Regional Director, Shelter Manager, and Quality Manager on 03/26
Program maintains minimum staffing ratios as required by Florida Administrative Code and contract. 1 staff to 6 youth during awake hours and 1 to 5 youth during offsite activities.	**Compliance**	The program maintains required staffing ratios in accordance with Florida Administrative Code and contract standards, ensuring a minimum of one staff to six youth during awake hours and one staff to five youth during offsite activities.
All shifts consistently maintain a minimum of two (2) staff present. Program staff included in the staff-to-youth ratio includes staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff.	**Compliance**	All shifts consistently maintain a minimum of two staff members on duty, with staff included in the ratio verified as background-screened and properly trained youth care, supervision, or treatment personnel.
The shelter has implemented policies and procedures to ensure youth safety when being supervised by staff of the opposite sex.	**Exception**	Upon initial review, the policy did not include protocols regarding supervision of youth by opposite sex staff. The Regional Director revised the policy to include safety protocols for supervision of youth by staff of the opposite sex.
The program staff schedule is provided to staff or posted in a place visible to staff.	**Compliance**	Staff schedules are provided and/or posted in a visible location to ensure adequate coverage and awareness of staffing assignments.
There is a holdover overtime rotation roster that includes home telephone numbers of staff who may be available when additional coverage is needed.	**Compliance**	A holdover and overtime rotation roster is maintained and includes contact information for staff available to provide additional coverage as needed.
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction. Times are documented in real time. (The times do not supersede requirements for constant supervision of youth at risk of suicide.)	**Exception**	Hope House missed one bed check on 3/15/26. One was completed at 11:30 and the next check was completed at 11:50.
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.	**Not Applicable**	The random sample of youth files reviewed did not include youth on Enhanced Supervision.
Additional Comments:		
5.5 - Behavior Management Strategies		**Satisfactory with Exception/s**
		Yes

Provider has a written policy and procedure that meets the requirement for Indicator 5.5		3.05 Behavior Management Strategies reviewed by Regional Director, Shelter Manager, Quality Manager on 03/26
A Behavior Management Strategy (BMS) is in place:		
The program has a detailed written description of the BMS and it is explained during program orientation.	**Compliance**	The program maintains a detailed written description of its Behavior Management Strategy (BMS), which is reviewed with youth during program orientation.
The written description of the behavioral management strategies include:		
A wide variety of positive incentives are used by the program.	**Compliance**	The written BMS outlines a wide variety of positive incentives used by the program to encourage appropriate behavior.
Appropriate interventions are used by the program to teach youth new behaviors and help youth understand the natural consequences for their actions.	**Compliance**	The BMS includes appropriate interventions designed to teach youth new skills and help them understand natural consequences for their actions.
Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior.	**Compliance**	Behavioral interventions are applied immediately, consistently, and proportionate to the severity of the behavior.
The Behavior Management Strategy includes:		
Consequences for violation of program rules are applied logically and consistently.	**Compliance**	Consequences for violations of program rules are applied logically, consistently, and fairly across all youth.
Program uses a variety of rewards/incentives to encourage participation and completion of the program.	**Compliance**	The program uses a variety of rewards and incentives to promote participation, engagement, and program completion.
All staff are trained in the theory and practice of administering BMS rewards and consequences.	**Exception**	It was reported that staff are trained in the theory and practice of the program's behavior management system, however the documentation found in the training files is insufficient to verify.
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.	**Exception**	It was reported that supervisors are trained to monitor the use of the program's behavioral interventions, however the documentation found in the training files is insufficient to verify.
There is a protocol for providing feedback and evaluation of staff regarding their use of the positive and negative consequences.	**Compliance**	The program has a clear protocol for providing feedback and evaluation to staff regarding their use of positive and negative consequences.
In general, BMS promotes order, safety, security, respect, fairness, and protection of resident rights.	**Compliance**	The BMS promotes order, safety, security, respect, fairness, and protection of youth rights throughout the program environment.
BMS provides constructive discipline that encourages youth to meet behavior expectations.	**Compliance**	The BMS provides constructive discipline that encourages youth to meet and maintain behavioral expectations.
BMS provides for positive reinforcement & recognition; constructive dialogue & peaceful resolution; and minimizes separation of youth from the general population.	**Compliance**	The BMS emphasizes positive reinforcement, recognition, constructive dialogue, and peaceful conflict resolution while minimizing unnecessary separation from peers.
Disciplinary measures do not deny the youth any of the following: regular meals and snacks, clothing, sleep, physical or mental health services, educational services, exercise, correspondence privileges, or contact with parents/guardians, attorney of record, juvenile probation officer or clergy.	**Compliance**	Disciplinary measures never deny youth access to meals, clothing, sleep, healthcare, education, exercise, communication privileges, or contact with parents/guardians, attorneys, probation officers, or clergy.
Additional Comments:		
5.6 - Program Orientation		**Satisfactory with Exception/s**
Provider has a written policy and procedure that meets the requirement for Indicator 5.6		Yes 3.02 Program Orientation reviewed by Regional Director, Shelter Manager, and Quality

		Manager
A total of five youth files were reviewed to evaluate the agency's Program Orientation process. Of these, three were open and two were closed files.		
During the first 24 hours following admission, the program must begin the orientation process, to include:		
Youth received a comprehensive orientation and handbook provided within 24 hours.	**Exception**	One youth admitted on 10/21/2025 did not sign the Orientation form until 10/31/2025 and one youth admitted on 3/5/2026 did not sign the form until 3/16/2026.
Youth Orientation is discussed with the youth and includes the following:		
Youth are given a list of contraband items.	**Compliance**	Youth are provided with a list of contraband items and understand restrictions for safety and security.
Behavioral Expectations and a review of the BMS	**Compliance**	Behavioral expectations are reviewed in detail, including an explanation of the program's Behavior Management Strategy (BMS).
Dress code explained	**Compliance**	The program's dress code is explained to youth during orientation.
Review of access to medical and mental health services	**Compliance**	Youth are informed of available medical and mental health services and how to access them.
Procedures for visitation, mail and telephone	**Compliance**	Procedures for visitation, mail, and telephone use are reviewed with youth during orientation.
Grievance procedure	**Compliance**	The program's grievance procedure is explained, including how to file a grievance and access grievance forms.
Disaster preparedness instructions	**Compliance**	Youth receive disaster preparedness instructions and understand emergency procedures.
Physical layout of the facility	**Compliance**	Youth are oriented to the physical layout of the facility, including key safety areas and exits.
Sleeping room assignment and introductions	**Compliance**	Sleeping room assignments are reviewed, and youth are introduced to peers and staff as part of the orientation process.
Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**Compliance**	Youth receive suicide prevention information, including how to alert staff if they or others experience suicidal thoughts.
Review of program schedule	**Compliance**	The daily program schedule is reviewed with youth to promote understanding of structure and expectations.
Additional Comments:		
5.7 - Youth Room Assignment		**Satisfactory with Exception/s**
Provider has a written policy and procedure that meets the requirement for Indicator 5.7		Yes
		3.03 Youth Room Assignment reviewed by Regional Director, Shelter Manager, and Quality Manager on 03/26
A total of five youth files were reviewed to evaluate the agency's Room Assignment process. Of these, three were open and two were closed files.		
The program determines room assignments during admission and intake using the following indicators:		
Review of youth's history, status & exposure to trauma	**Compliance**	Youth classification includes a thorough review of the youth's history, current status, and exposure to trauma to ensure safe and appropriate placement.
Collateral contacts	**Compliance**	Staff make collateral contacts, as needed, to gather additional information relevant to youth classification and safety.
Initial interactions with and observations of the youth	**Exception**	One youth did not have initial interactions and observations documented as part of the room assignment process.
Separation of younger youth from older youth	**Compliance**	Younger youth are housed separately from older youth to promote safety and developmental appropriateness.

Separation of violent youth from non-violent youth	**Compliance**	Youth with a history of violent behavior are separated from non-violent youth to reduce risk and maintain safety.
Identification of youth susceptible to victimization	**Compliance**	Youth identified as susceptible to victimization are assigned rooms that promote protection and increased supervision.
Presence of medical, mental, or physical disabilities	**Compliance**	Youth with medical, mental health, or physical disabilities are appropriately classified to ensure their needs are safely accommodated.
Suicide risk	**Compliance**	Youth are screened for suicide risk upon admission, and any identified concerns are addressed immediately through safety planning and supervision.
Sexually aggressive and predatory behavior	**Compliance**	Youth exhibiting sexually aggressive or predatory behaviors are identified and separated to maintain the safety of others.
Acute health symptoms requiring quarantine or isolation	**Compliance**	Youth presenting acute health symptoms are appropriately quarantined or isolated in accordance with health and safety protocols.
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors.	**Exception**	The program's policy states a colored dot system of red for high risk, yellow for CSS, and green for medication is to be used. None of the files that would warrant a dot had a dot on the file. There is a board in the office that is marked if a youth is on medication or CSS, though not high risk.
Additional Comments:		
5.8 - Video Surveillance		**Satisfactory with Exception/s**
Provider has a written policy and procedure that meets the requirement for Indicator 5.8		Yes
		3.07 Video Surveillance reviewed by Regional Director, Shelter Manager, and Quality Manager on 03/206
The agency has a system in operation 24 hours a day, 7 days a week. Does it demonstrate:		
A written notice that is conspicuously posted on the premises for the purpose of security; *(for all staff, youth, and visitors, advising if the program has a surveillance system that records both audio and video, indicating consent to audio and video recording). *	**Compliance**	A written notice indicating video surveillance for security purposes is conspicuously posted on the premises.
Cameras are in the interior (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit (including locations where youth searches are conducted).	**Compliance**	Cameras are positioned in key interior areas (e.g., intake office, counseling rooms, cafeteria, and dayroom) and exterior locations (e.g., entrances, exits, recreation areas, and parking lots) where youth, staff, and visitors congregate or pass through.
All cameras are visible.	**Compliance**	All cameras are clearly visible and serve as an effective deterrent to unsafe or prohibited behavior.
No cameras are placed in bathrooms or sleeping quarters.	**Compliance**	Cameras are not placed in bathrooms or sleeping quarters, ensuring the privacy and dignity of youth and staff.
The system can capture and retain video photographic images, which must be stored for a minimum of 30 days.	**Compliance**	The video surveillance system captures and retains recordings for a minimum of 30 days in compliance with program requirements.
The system can record date, time, location, and maintain a resolution that enables facial recognition.	**Compliance**	The system records date, time, and location, maintaining sufficient resolution to enable facial recognition when needed.
Cameras can operate during a power outage.	**Compliance**	Cameras and recording equipment remain operational during power outages, supported by backup systems.

A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel).	**Compliance**	A current list of designated personnel authorized to access the surveillance system, including off-site access permissions, is maintained and up to date.
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook. The reviews assess the activities of the facility and include a review of a random sample of overnight shifts.	**Exception**	For Currie House a supervisory review was noted on January 10th, the next review did not occur until February 6th, and no reviews were noted between February 16-March 12. For Hope House, a supervisory review was noted on September 21st, the next reviews did occur until October 12th , November 25th, February 6th. No reviews were noted to have been conducted between February 17th and March 18th.
Requests for video recordings pursuant to investigations or quality improvement visits are provided within 24-72 hours of the request.	**Exception**	Video of an incident that occurred on December 14th was not provided to the CCC until December 31st.
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. There is evidence that all efforts made to obtain repairs are documented and maintained.	**Not Applicable**	There have been no issues reported that would require a work order. The Shelter Manager reported that if the system malfunctioned, the program would submit a work order to IT within 24 hours.
Additional Comments:		
Domain Six		
6.0 - Medication Management and Distribution		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 6.0		Yes 4.03 Medications Administration, Revised/approved by Regional Director on 3/16/2026
A total of three Medication Management and distribution files wee reviewed during this evaluation period. Of these, two were open and one was closed.		
The agency has an internal quality improvement process to ensure appropriate medication management and distribution methods to track medication errors and identify systemic issues and implement mitigation strategies, as appropriate.	**Compliance**	The agency maintains an active quality improvement process to monitor and enhance medication management and distribution practices, addressing errors and implementing mitigation strategies as needed.
All non-nursing shelter staff designated to assist with the self-administration of medication receive in-person medication administration training: a. provided by a Registered Nurse b. demonstrate competency c. maintain re-certification annually	**Compliance**	All non-nursing shelter staff designated to assist with self-administration of medications receive in-person training provided by a Registered Nurse, demonstrate competency, and maintain annual re-certification.
There is evidence of, at least, quarterly staff meetings conducted by RN and/or Shelter Manager to: a. review and assess strategies implemented to reduce medication errors shelter wide b. analyze factors that contributed to medication errors c. allow staff the opportunity to practice and role-play solutions	**Compliance**	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.

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.	**Compliance**	Staff authorized to assist with medication distribution are clearly designated on the staff schedule and shift responsibility forms for every shift.
The program has strategies to ensure medications are provided within the time frame.	**Compliance**	The program has established procedures to ensure medications are administered within required timeframes.
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.	**Compliance**	A clear communication system is maintained to ensure staff on each shift can easily identify youth medication schedules, including times and dosages.
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.	**Not Applicable**	Both shelters have had zero medication errors during FY 24/25 and thus far in FY 25/26, therefore no refresher training has been provided to staff responsible for medication errors. The RN reported that she attends shelter staff meetings monthly and does provide refresher trainings to staff to prevent medication errors.
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.	**Not Applicable**	Both shelters have had zero medication errors during FY 24/25 and thus far in FY 25/26, therefore no staff are responsible for 3 errors within a 1-year time frame.
All medications (included narcotics and controlled medications) are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth.	**Compliance**	All medications, including controlled substances, are securely stored in a Pyxis ES Medication Cabinet that is inaccessible to youth.
Pyxis machine stored in accordance with guidelines in Florida Statute 499.0121 and policy section Medication Management. FS 499.0121 states the establishment where medications are stored must: (a) Be of suitable size and construction to facilitate cleaning, maintenance, and proper operations; (b) Have storage areas designed to provide adequate lighting, ventilation, temperature, sanitation, humidity, space, equipment, and security conditions; (c) Have a quarantine area for storage of prescription drugs that are outdated, damaged, deteriorated, misbranded, or adulterated, or that are in immediate or sealed, secondary containers that have been opened; (d) Be maintained in a clean and orderly condition; and (e) Be free from infestation by insects, rodents, birds, or vermin of any kind.	**Compliance**	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.
Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station.	**Compliance**	The agency maintains a minimum of two site-specific Pyxis ES System Managers to ensure continuous oversight and accountability.
Oral medications are stored separately from injectable or topical medications.	**Compliance**	Oral medications are stored separately from injectable and topical medications to prevent cross-contamination.

Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose.	**Compliance**	Medications requiring refrigeration are stored in a secure, designated refrigerator or within a secured room inaccessible to youth.
Temperature requirements are 2-8 degrees C or 36-46 degrees F for storage of medications.	**Compliance**	Medication refrigeration units are consistently maintained at 2–8°C (36–46°F) to meet temperature requirements.
Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics).	**Compliance**	Only authorized staff listed in User Permissions have access to secured medications, with restricted access to controlled substances.
Perpetual inventory with running balances are maintained for controlled substances.	**Compliance**	Controlled substances are tracked through a perpetual inventory system maintaining real-time running balances.
Shift-to-shift counts (verified by a witness and is documented) are conducted and documented for controlled substances.	**Compliance**	Shift-to-shift counts of controlled substances are conducted and documented by two staff members to ensure accuracy and accountability.
Non-controlled medication and over-the-counter medications that are accessed regularly are inventoried weekly.	**Compliance**	Regularly accessed non-controlled and over-the-counter medications are inventoried weekly to ensure proper tracking.
Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly.	**Compliance**	Syringes and sharps are securely stored, counted, and documented on a weekly basis.
There are monthly reviews of Pyxis Reports to monitor medication management practice.	**Compliance**	Monthly Pyxis reports are reviewed to monitor medication management practices and identify any trends requiring corrective action.
Medication is verified using one of the three methods outlined in Policy 4.02: 1. Contact Pharmacy 2. Registered Nurse or Licensed Practical Nurse 3. Pill Identifier (Pill Finder) – Drugs.com	**Compliance**	Medications are verified using approved methods as outlined in Policy 4.02, including contact with the pharmacy, verification by registered or licensed nursing staff, or using a validated pill identifier site by the nurse or trained/certified staff.
When nurse is on duty, medication processes are always conducted by the nurse. If nurse or licensed healthcare staff is not onsite, then the designated staff who has been trained to assist in the self-administration of medication distribution by a licensed Registered Nurse is responsible to provide the medication.	**Compliance**	When a nurse is on duty, all medication administration processes are conducted by nursing staff; when unavailable, trained and certified staff perform distribution under established procedures.
The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy.	**Compliance**	The medication delivery process fully aligns with Florida Network's Medication Management and Distribution Policy.
All discrepancies are cleared each shift.	**Compliance**	All medication discrepancies are identified, reviewed, and cleared at the end of each shift.
Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a) TOP COVER b) BACK PANEL- LEFT TALL CABINET LOCK- LEFT c) BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	**Compliance**	Pyxis system keys labeled "TOP COVER," "BACK PANEL-LEFT," and "BACK PANEL-RIGHT" are accessible to staff for emergency access in the event of a system malfunction, with all access appropriately documented.
A Medication Distribution Log is used for the distribution of medication by non-licensed and licensed staff.	**Compliance**	A Medication Distribution Log is consistently used by both licensed and non-licensed staff to record the administration of all medications.

The documentation includes the time of administration on the Medication Distribution log and evidence of both (youth and staff initials) that the dosage was given.	**Compliance**	Documentation on the Medication Distribution Log clearly reflects the time of administration and includes the initials of both the youth and the administering staff member as verification.
Staff shall assist youth with medications within one hour of the scheduled time of delivery as ordered by the medication. E.g. 0730 medication can be given between 0630 – 0830.	**Compliance**	The nurse or designated staff member distributes medications within one hour of the scheduled delivery time in accordance with medical orders, ensuring timely and accurate dosage.
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.	**Compliance**	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.
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.	**Compliance**	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
Additional Comments: Observed RN administer medication to youth at Hope House on 3/17/2026. The RN signed into Pyxis, reviewed youth's MDR, pulled medication bottle from the drawer and put the required dosage in a small container. The RN asked the youth to identify herself and the medication/dosage, and RN asked youth to show that she swallowed the medication. Both RN and youth initialed in the MDR. Additionally, an unlicensed, trained YCS staf was observed conducting an afternoon medication pass at Hope Hose on 3/17/2026 in accordance with policy. The staff was observed verifying youth identity and medication type/dosage. After the med pass, the staff was able to explain the process of medication administration and the operation of the Pyxis machine. Currie and Hope House have had ZERO medication errors in FY 24/25 and thus far in FY 25/26. The strategies the shelters utilize to prevent medication errors include: assigning a specific staff member responsible for medications on each shift, utilizing alarms to remind staff of medication times, encouraging staff to administer medications within the first 30 minutes of the two hour window, having RN attend monthly staff meetings to provide refresher training and having staff call on-call supervisor to confirm medications have been given within time frames. If staff call is not received by the last 30 minutes of the 2 hour window, the on-call supervisor has an opportunity to call staff and remind them within the timeframe. Staff report that this process has prevented a number of potential errors since implementation.		
6.1 - Naloxone Administration and Opioid Overdose Response		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 6.1		Yes 4.06 Naloxone Policy, Revised on 10/25/25 and Reviewed 3/10/2026 by Regional Director
Naloxone is stored between 37 and 77 degrees F and is stored with a cold pack when transported in vehicles to maintain effectiveness.	**Compliance**	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.
Additional Comments: Naloxone was observed to be stored within access of staff in both shellers and in the Pyxis machine.		
6.2 - Suicide Prevention		**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 6.2		Yes Policy 4.2, Suicide Assessment, was last revised on 03/10/2026 by Regional Director, Shelter Services Manager, Quality Management Specialist.
A total of six file(s) were reviewed during this evaluation period. Of these, one was open and five were closed. Among the open file(s), one community counseling file was reviewed. Among the closed file(s), four residential (RES) and one community counseling file(s) were reviewed.		
Upon intake, every youth is screened for suicidality using the five Florida Network questions.	**Compliance**	All youth are consistently screened for suicidality during intake using the five Florida Network questions.

Screening results are reviewed, signed by a supervisor, and filed in the youth's case record.	**Exception**	Two out of six files reviewed did not have the screening results reviewed and signed by a supervisor.
A "yes" to any question triggers a full suicide risk assessment by: 1. A Licensed Mental Health Professional (LMHP), or 2. A non-licensed clinician under direct LMHP supervision.	**Compliance**	All screens that triggered a positive response for suicide risk demonstrated that a full suicide risk assessment was completed by a qualified LMHP or a clinician under direct LMHP supervision.
Assessment of Suicide Risk must be completed and reviewed by the LMHP within 24 hours of a positive screen.	**Exception**	Two out of six files reviewed did not have a suicide risk assessment completed within 24 hours of positive screening.
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.	**Exception**	One out of six files reviewed was missing an assessment and had no detailed documentation of assessment occurring.
If conducted by a non-licensed staff member, the LMHP must co-sign and date as reviewer the next time they are on-site.	**Compliance**	When assessments are conducted by non-licensed staff, LMHPs consistently co-sign and date the review during their next on-site visit.
Parents/guardians and the Program Supervisor are notified immediately of any youth determined to be at risk or following a suicide attempt. All notification efforts (in-person, phone, certified mail) are documented in the case file.	**Exception**	Two out of six files reviewed did not have documentation of the parent/guardian being notified of suicide risk.
If a youth poses an immediate threat to self or others at any time, staff follow Baker Act protocols and/or call 911.	**Not Applicable**	The randomly selected files for review did not include youth that were deemed to be at imminent risk for suicide and subject to Baker Act procedures, however a review of the policy/procedure details the process to be utilized in the event a youth is assessed to be at immediate risk of harm to self or others.
Documentation & Family Notification		
All screenings, assessments, supervision actions, and shift-to-shift handoffs are logged in the daily shelter/counseling logbook.	**Exception**	Four out of four residential files reviewed did not have documentation pertaining to suicide screening, assessment, or supervision actions documented in the logbook.
If a guardian cannot be reached in person, telephone contact attempts are documented; and written notice is sent by certified mail.	**Exception**	Two out of six files reviewed did not have written notice by mail if parent could not be contacted by phone.
Community Counseling Only: When an immediate assessment is not possible, families receive community resource information.	**Not Applicable**	Assessments occurred immediately for Community Counseling cases reviewed.
Community Counseling Only: Any screening conducted on school property during school hours is reported to appropriate school authorities.	**Not Applicable**	No screenings were 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.	**Exception**	For two out of four residential clients reviewed it could not be determined in the file or the log book that sight and sound observation was initiated for the youth.

Residential Only: Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	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.	**Exception**	Two out of four residential clients had observations more than 30 minutes apart.
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.	**Compliance**	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.
Additional Comments:		
6.3 - Healthcare Admission Screening		**Satisfactory with Exception/s**
Provider has a written policy and procedure that meets the requirement for Indicator 6.3		Yes 4.01 Healthcare Admission Screening; 03/10/2026
A total of five Healthcare Admissions Screening file(s) were reviewed during this evaluation period. Of these, three were open and two were closed.		
The primary healthcare screening is completed by the nurse if he/she is present during the intake. If not present during the intake, the nurse reviews the primary healthcare screening within 3 business days.	**Exception**	In one youth record reviewed, the healthcare admission screening form reviewed by the RN was completed one day late.
The primary healthcare screening and observations include:		
Current medications	**Compliance**	The primary healthcare screening includes verification and documentation of all current medications.
Existing (acute and chronic) medical conditions	**Compliance**	Existing acute and chronic medical conditions are accurately identified and recorded.
Allergies	**Compliance**	Any allergies are clearly documented during the screening process.
Recent injuries or illnesses	**Compliance**	Recent injuries or illnesses are reviewed and noted as part of the assessment.
Observation for evidence of illness, injury, pain or physical distress, difficulty moving, etc.	**Compliance**	Staff document careful observations for signs of illness, injury, pain, physical distress, or mobility difficulties.
The program has procedures to include a thorough referral process and a mechanism for necessary follow-up medical care for youth admitted with chronic medical conditions.	**Compliance**	Youth exhibiting symptoms requiring quarantine or isolation are promptly identified, and appropriate protocols are followed.
All medical referrals are documented on a daily log.	**Compliance**	Parents and guardians are engaged in coordinating and scheduling follow-up medical appointments as needed.
Additional Comments:		
6.4 - Medical/Mental Health Alert Process		**Failed**
Provider has a written policy and procedure that meets the requirement for Indicator 6.4		Yes 4.04 Medical and Mental Health Alert Process reviewed by Regional Director, Shelter Manager, and Quality Manager on 03/26
A total of five Medical/Mental Health Alert Process file(s) were reviewed during this evaluation period. Of these, three were open and two were closed.		
If youth has a medical or mental health condition or allergies, they are appropriately placed on the program's alert system.	**Exception**	Three of five youth reviewed did not have alerts listed on the chart according to program's policy.
Alert system includes precautions concerning prescribed medications and potential side effects.	**Compliance**	Staff receive clear information and instructions enabling them to recognize and appropriately respond to medical or mental health emergencies.

Staff are provided sufficient information/ instructions to recognize/respond to the need for emergency care for medical/mental health problems.	**Exception**	The policy does not match the practice which resulted in missing a high-risk alert for a youth.
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.	**Exception**	The policy doesn't match the practice which resulted in missing a high risk alert for a youth. The policy states there are red (for high risk), green (for medication), and yellow (for CSS) dot stickers. Practice shows a white board alerting for CSS and medication, no colored stickers as the policy states, and there is no notification for high risk on the white board .