



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

LSF Southeast-Lippman Youth Shelter

221 NW 43rd Ct, Oakland Park, FL 33309

March 31-April 1, 2026

EXECUTIVE SUMMARY

A Quality Improvement (QI) monitoring visit was conducted for LSF Southeast for FY 2025-2026 at its program office located at 221 NW 43rd Ct, Oakland Park, FL 33309. The onsite review is intended to assess the agency's adherence to fiscal, programmatic, and overall contract requirements. LSF Southeast 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 the Florida Network for Youth and Family Services. The following representatives from LSF Southeast were present for the entrance interview: Raymond Ballinger, Regional Director; Lisa Skirving, Shelter Manager; Taneshea Sargent, Clinical Director; Ivonne Fusco, HR/Administrative Specialist, and Yves Hilarie, Outreach Specialist. The last onsite QI visit was conducted on November 13-14, 2024.

In general, the reviewer found that LSF Southeast is in compliance with specific contract requirements. LSF Southeast received an overall compliance rating of 100% for achieving full compliance with 14 indicators of the CINS/FINS Monitoring Tool. One indicator was not applicable. There were no recommendations or corrective actions as a result of the monitoring visit.

The following report represents the results of the in-depth evaluation of the provider's General Administrative performance, with all findings clearly documented. Copies of all completed tools utilized during the visit to determine these ratings will be maintained on file with the Reviewer. If any information or clarification is required, please contact Laura Moneyham by E-mail: laura@floridanetwork.org

2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL

Agency Name: LSF Southeast					Monitor Name: Laura Moneyham		
Contract Type: CINS/FINS					Region/Office: 221 NW 43 rd Ct, Oakland Park, FL 33309.		
Service Description: Comprehensive Onsite Compliance Monitoring					Site Visit Date(s): March 31-April 1, 2026		
Explain Rating							
					Ratings Based Upon:		Notes
Major Programmatic Requirements	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.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The provider has two active/certified Peer Reviewers: Taneshea Sargent, Clinical Director and Lisa Skirving, Shelter Manager. Both are scheduled to participate in one or more QI Reviews in FY 25/26.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The provider provided a current list of all contracts, federal, state and local. This list included the awarding entity and contract start & end dates.	
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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The provider provided their current Certificate of Liability Insurance, with the Florida Network as the Certificate holder, effective dates:	

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Major Programmatic Requirements						I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Explain Unacceptable or Conditionally Acceptable:
insurance as required by Chapter 440, F.S. with a minimum of \$100,000 per accident, \$100,000 per person and \$500,000 policy aggregate. Commercial General Liability with a limit of \$500,000 per occurrence, and \$1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of \$250,000 per person; with a minimum limit for bodily injury of \$500,000 per accident; with a minimum limit for property damage of \$100,000 per accident and with a minimum limit for medical payments or \$5,000-\$10,000 per person. Florida Network is listed as payee or co-payee. PTV						6/1/2025 – 6/1/2026 and it meets all the required limits of coverage.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The Regional Director reported that the program is not currently on a corrective plan with any outside funder.	

2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL

Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency has written employee and fiscal policies that comply with GAAP and provide sound internal 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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The Agency maintains a general ledger which tracks the grant activity separately and provided the correlating bank reconciliations and statements.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) – ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The Regional Director reported that the program utilizes Petty Cash for minor purchases (no more than \$300 on site) for vendors who don't accept their corporate credit card. Disbursements and reconciliations are conducted by the fiscal department at the corporate office.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency maintains bank reconciliations and statements.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. In the event the provider has purchased computer equipment, an Informational Resources Request (IRR) has been submitted to DJJ. PTV/ Verify ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	The Regional Director reported that the program has not purchased any items with FY 25/26 funds and has not purchased property with FN funds. An inventory list was provided with no additional purchases.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable) PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The Agency provided documentation that supports payroll taxes and deposits.	
g. Budget to actual reports prepared and reviewed by appropriate management. PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency provided budget to actual year-to-date report as of January 31, 2026.	

2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL

<p>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</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>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.</p>	
<p>i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. PTV</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>The Agency maintains confidentiality policy that ensures the security and privacy of all employee and client data. The policy also addresses back-up of files and security procedures to protect hardware.</p>	
<p>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</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>A review of agency's current salary list shows evidence that every direct care staff is paid at least \$19.00 per hour.</p>	
<p>Disaster Planning k. The agency has a written policy and procedure that includes a policy title/number, date of last review/revision, meets all of the requirements for the indicator that has been approved. The agency has a comprehensive Disaster Preparedness Plan that includes the following: <ul style="list-style-type: none"> o Emergency evacuation protocols o Severe weather procedures o Evacuation logistics (shelter only) o Evacuation facility designation (shelter only) o Critical Resource Planning o Florida Network and DJJ notification requirements The Universal Agreement/Emergency Disaster Shelter document is signed by the agency executive. The</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>The agency submitted a Continuing of Operations Plan (COOP) that met all the requirements and the Universal Agreement was signed by the Regional Director, Raymond Ballinger.</p>	

2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL

comprehensive Disaster Preparedness Plan is submitted to the Florida Network annually, no later than February 1st. PTV							
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2025-2026 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL

CONCLUSION

LSF Southeast has met the requirements for the CINS/FINS contract as a result of full compliance with 14 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. One of the 15 indicators was not applicable because the program did not purchase any items with Florida Network funds in FY 25/26. 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.

SUMMARY OF CORRECTIVE ACTIONS or RECOMMENDATIONS

No corrective actions are required.

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 Southeast-Lippman Youth Shelter

CINS/FINS Programs

March 31-April 1, 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.

Reviewers

Laura Moneyham-QI and Compliance Manager, Florida Network of Youth and Family Services
Rondarrell George-Regional Monitor, Department of Juvenile Justice
Wendy Pierre-McNealy-Training Manager, Florida Network of Youth and Family Services
Christina Blanchard-Clinical Supervisor, Family Resources
Duane Gross-Residential Program Manager, Children's Home Society

Monitoring Purpose

The purpose of this monitoring is to provide an annual quality improvement program review. This is to verify the agency adheres to all current CINS/FINS standards and contract compliance requirements for residential and/or community counseling services.

Program Update/Notables

The program has increased its focus on outreach and partnership development to address referral challenges. The LSF SE Outreach Specialist has expanded the program's community presence and strengthened partnerships. Expanded Outreach efforts include weekly outreach to schools and community partners, development of partnerships with organizations such as the Boys & Girls Clubs of Broward County, diversification of referral sources beyond traditional school-based channels. The program is reviewing the high volume of referrals received through Miami Bridge Youth & Family Services to identify families located near the Broward/Miami-Dade border who may be appropriate for Broward-based services, pending proper approvals. This strategy is intended to maximize service reach and ensure access for eligible families. The absence of a finalized Broward County interagency agreement remains a significant systemic barrier affecting referral flow. Per communication with DJJ, multiple stakeholder meetings occurred between November and December, and the agreement is currently under review by General Counsel for Broward County Public Schools. At this time, the process is still pending, and referral pathways continue to be limited. The Lippman facility is undergoing a major capital improvement project funded through the Jim Moran Foundation. This initiative aligns with QI standards related to safety, environment, and program quality. The project scope includes interior renovations (kitchen, bathrooms, HVAC-related work, and furnishings), exterior improvements (lighting, fencing, landscaping, and safety enhancements), and infrastructure upgrades (accessibility improvements, generator installation, and recreational space enhancements). The project is currently in the permitting phase. It is anticipated that the construction phase will take 90-120 days. The program was

also awarded \$10,000 in September 2025 through the Broward County Law Enforcement Trust Fund. These funds are being used to support youth outings and other pro-social activities, enhancing enrichment opportunities and positive youth development within the program.

CINS/FINS Rating Profile

Domain 1: Background Screening and Compliance

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

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

Domain 3: Screening, Assessment & Case Management

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 5: Shelter Program Services

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

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

Domain 6: Medical & Mental Health

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

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

Overall Rating Summary

% Indicators rated Satisfactory:	90.00%
% Indicators rated Limited:	10.00%
% Indicators rated Failed:	0.00%

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

1.4 Training Requirements-Limited: The following required training was missing from program policy and staff training logs: It's All About Reporting, Naloxone Overdose Prevention, Statewide Lockout, Fire Safety, CPR, Adolescent Development / Positive Youth Development, Cultural Humility and Diversity, and New Hire Onboarding Specific Trainings. The following training was late or missing from one or more of the six new-hire files reviewed: Civil Right & Federal Funds, Fire Safety Equipment (In-person and SkillPro), CPR/First Aid, Florida Network Suicide Prevention, Adolescent Development, Cultural Humility, Child Abuse: Recognition, Reporting and Prevention, Equal Employment Opportunity, Human Trafficking for Direct Care Staff, Information Awareness, PREA Parts I & II, Sexual Harassment, Trauma Responsive Practices, Naloxone Training, Statewide Lockout Protocol, NIRVANA Assessment, and Suicide Assessment Training for Non-licensed Clinical staff. The following training was late or missing from one or more of the six annual files reviewed: Child Abuse: Recognition, Reporting and Prevention, Human Trafficking for Direct Care Staff, Information Awareness, It's All About Reporting, PREA Parts I & II, Sexual Harassment, Trauma Responsive Practices, Florida Network Suicide Prevention, CPR/First Aid, Fire Safety Equipment (In-person and SkillPro). Files reviewed did not include documentation or notation for delay and/or incompleteness status and anticipated completion date. The Shelter Manager updated this process during the review to include a document in the file that includes notation, staff signature, and date. Although direct care shelter staff are receiving ongoing training, as evident in other documentation, staff training trackers do not reflect the full total of all completed trainings. The shelter manager has updated the documentation to accurately reflect total completed hours for all training.

3.3 NIRVANA-Limited: Three of five Community Counseling files had NIRVANAs completed by a Counselor without record of completing the NIRVANA training. Four of five Community Counseling files had NIRVANAs entered into NetMIS after the 3-business day window (two were 7 business days, one was 9 business days, and one was 69 business days). Eight of ten total files had supervisor signatures documented after the 7-day window. Timelines include 9, 12, 13, 14, 25, 86, 90, and 176 business days between assessment completion and supervisor signature. Supervision binder documentation indicates that shelter files and service plans are being reviewed on weekly basis, but documents are not being consistently signed at time of supervision discussions. A total of three of ten files reached a 90-day period, triggering the need for a NIRVANA Re-assessment. Files were closed shortly after the 90-day period and only had a NIRVANA post-assessment completed at the time of discharge.

3.4 Case Management, Counseling-Limited: Direct supervision logs document monthly staff supervision as opposed to weekly supervision. Shelter supervision notes include more frequent file reviews occurring every week outside of logged monthly supervision. Supervisor intends to ensure that weekly check-ins with all clinical staff are additionally documented in log moving forward as well as in calendar for tracking purposes. No additional exceptions found within shelter files. Three of five Community Counseling files indicated a period greater than 30 days of no services without file closure. Five of five Community Counseling files do not have weekly service engagement documented in file or NetMIS. Gaps in services for weeks of non-engagement are not documented in file or NetMIS weekly.

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
X	Program Manager		Direct Care- PRN	X	Maintenance Personnel
X	Clinical Director		Intern		Other:
X	Program Coordinator		Volunteer		
	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	12	# Employee/Intern/Volunteer Records
X	Logbooks	X	Medical/MH Alerts	12	# Training Records
X	Continuity of Operation Plan	X	Precautionary Observation	6	# Youth Records (Closed)
X	Egress Plan	X	Program Schedules	4	# 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/Interviews

5	# of Youth	3	# of Staff	# of Others
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QUALITY IMPROVEMENT PROGRAM REPORT VALIDATION & CERTIFICATION

Program Name: LSF Southeast-Lippman Shelter

Service Type(s): CINS/FINS SHELTER

Dates of Review: 3/31/26-4/1/26

Date Report Received: 4/24/2026

Date Certification Completed: 4/26/2026

Domain Indicator	Indicator Name	Current Rating	Agreement w/ Report Rating	Revised Rating	Disagreement Justification
1.0	Background Screening & Compliance	SATISFACTORY	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	YES		
1.4	Training Requirements (Policy & New Hire)	LIMITED	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	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	N/A			
4.1	SNAP® Fidelity Monitoring	N/A			
4.2	SNAP® for Youth	N/A			
4.3	SNAP® Youth Justice	N/A			
4.4	SNAP® Under 12 Case Management Services for Fathers	N/A			
4.5	SNAP® for Schools and Communities	N/A			
5.0	Shelter Program Services	SATISFACTORY	YES		
5.1	Shelter Environment	SATISFACTORY	YES		
5.2	Shelter Search Policy	SATISFACTORY	YES		
5.3	Lookbook Requirements	SATISFACTORY WITH EXCEPTIONS	YES		
5.4	Staffing Standards and Enhanced Supervision	SATISFACTORY	YES		
5.5	Behavior Management Strategies	SATISFACTORY	YES		
5.6	Program Orientation	SATISFACTORY	YES		
5.7	Youth Room Assignment	SATISFACTORY	YES		
5.8	Video Surveillance	SATISFACTORY	YES		
6.0	Medication Management and Distribution	SATISFACTORY	YES		
6.1	Naloxone Administration and Opioid Overdose Response	SATISFACTORY	YES		
6.2	Suicide Prevention	SATISFACTORY	YES		
6.3	Healthcare Admission Screening	SATISFACTORY WITH EXCEPTIONS	YES		
6.4	Medical/Mental Health Alert Process	SATISFACTORY	YES		
Overall	Final Percent of Indicators Rated Satisfactory	90.00%			
Overall	Final Percent of Indicators Rated Limited	10.00%			
Overall	Final Percent of Indicators Rated Failed	0.00%			

Certified By:

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
Provider has a written policy and procedure that meets the requirement for Indicator 1.0		Yes
Provider has implemented a Suitability Assessment policy and procedure that meets the requirement for Indicator 1.0		Yes
A total of seven file(s) were reviewed during this evaluation period. Of these six new hire file(s) and one 5-year rescreen file(s) were reviewed. The sample included six full-time employee(s), one part-time employee, and no 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?	Compliance	All applicant files confirmed a passing result for the suitability assessment.
Employees who have a break in service may be reemployed with the same agency without an additional suitability assessment if the break is less than eighteen (18) months. However, if the provider changed or updated the assessment tool used, there is evidence that the employee completed the new assessment.	Not Applicable	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.	Compliance	Background screenings for all new hires (employee, contractors, volunteers and interns working more than 10 hours/ month) were completed, and eligibility was confirmed prior to each hire 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.	Compliance	All five-year re-screenings were completed on or before the employee's five-year anniversary or fingerprint expiration date, whichever came first.
Additional Comments:		
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
		Approved on 12-9-25 and reviewed on 3-10-26 by Regional Director, Shelter Services Manger and Clinical Director.

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
		Approved on 12-9-25 and reviewed on 3-10-26 by Regional Director, Shelter Services Manger and Clinical Director.
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
Provider has a written policy and procedure that meets the requirement for Indicator 1.3		Yes
		Approved on 12-9-25 and reviewed on 3-10-26 by Regional Director, Shelter Services Manger and Clinical Director.
Data sources Reviewed	Dates Reviewed	Logbook Dates for Sample Size:
Florida Department of Juvenile Justice Center Communication Center, Program Logbook.	09/01/2025 TO 03/31/2026	9/15/25,9/17/25,9/27/25,10/5/25,10/7/25,10/21/25,11/25/25,12/7/25,12/21/25,1/14/26,1/17/26,3/2/26,3/22/26
CCC Daily Report	Compliance	The program consistently reported incidents to the CCC within the required two-hour timeframe.
Between 08/01/2025 12:00 AM and 03/31/2026 11:59 PM	Compliance	The program completed all follow-up communication and special instructions from the CCC.
Incidents are documented in the program logs, and the CCC call is documented in the logbook for Shelter programs.	Compliance	Incidents and CCC calls were documented in the program logs and logbooks as required.
Agency internal incidents are documented on incident reporting forms or electronically and all CCC reportable incidents were consistently reported to CCC as required.	Compliance	Agency internal incidents are consistently documented using approved incident reporting forms or electronic systems, and all CCC-reportable incidents are reported to the CCC in accordance with established requirements.
All incident reports are reviewed and signed by program supervisors/directors.	Compliance	All incident reports were reviewed and signed by program supervisors or directors.
1.4 - Training Requirements		Limited
Provider has a written policy and procedure that meets the requirement for Indicator 1.4		No
		1.04 Training Requirements 3/10/2026
A total of 4 first-year non-licensed Mental Health Clinical Shelter staff file(s) were reviewed. Six new hire staff and six annual staff files were reviewed for compliance with training completed within the required timeframe(s).		
Policy & New Hire Training		
Trainings that are required by the Network and other funders must be documented in each individual staff member's file and on the FLN Training Log or similar document with the minimum requirements i.e. Staff Name & Position, Date of Hire, Training anniversary used by agency (calendar, date of hire or fiscal), Training Name, Training Hours, Cumulative Total, Training Completion or Facilitation Date, Location of Training or Platform Used (when virtual).	Exception	Required trainings were missing from program policy and staff training logs. Program will update tracker to ensure all files and Relias LMS will include It's All About Reporting, Naloxone Overdose Prevention, Statewide Lockout, Fire Safety, CPR, Adolescent Development / Positive Youth Development, Cultural Humility and Diversity, and New Hire Onboarding Specific Trainings.

Civil Rights & Federal Funds (United States Department of Justice) (Required within 30 DAYS of date of hire)	Exception	One of the six files reviewed completed the Civil Rights & Federal Funds (U.S. Department of Justice) training outside the required timeframe (within 30 days of hire) and did not include any notation in tracker/file.
Pre-Service Training		
Agency policies and procedures	Compliance	All new staff completed agency orientation and policy training prior to working independently.
Contraband Overview and Search Policy/Practice AND signed acknowledgment form by staff.	Compliance	Staff reviewed the Contraband Overview and Search Policy and signed the required acknowledgment form.
Behavior Management	Compliance	Behavior Management training was completed prior to independent work with youth.
Risk Management	Compliance	All Staff hired after Jan 28, 2026 completed Risk Management Training prior to working independently with youth.
It's All About Reporting	Compliance	All Staff hired after Jan 28, 2026 completed Its' All About Reporting training prior to working independently with youth.
Building/Facility layout	Compliance	Staff received orientation to the building and facility layout.
File Documentation/Paperwork Requirements	Compliance	File documentation and paperwork requirement training was completed as required.
Confidentiality (FYSB / DCF / Skill Pro)	Compliance	Confidentiality training (FYSB / DCF / SkillPro) was completed and documented in staff files.
CCC & Incident Reporting	Compliance	Staff completed CCC and Incident Reporting training prior to working independently.
Child Abuse Reporting	Compliance	Child Abuse Reporting training was completed and verified in the staff record
Client Intake & Screening	Compliance	Client Intake and Screening training was completed prior to independent case assignment.
Client Orientation (Shelter only)	Compliance	Staff completed Client Orientation training on delivering new client orientations.
Fire Safety Equipment (In-person by a supervisor or other program trainer)	Exception	Two of the six reviewed files completed Fire Safety Equipment training outside the required timeframe and did not include any notation in the tracker/file.
Fire Safety Equipment (Skill Pro #215 or DCF)	Exception	Two of the six reviewed files completed Fire Safety Equipment training outside the required timeframe and did not include any notation in the tracker/file.
Medical and Mental Health Alert System	Compliance	Medical and Mental Health Alert System training was completed as required.
Disaster Preparedness	Compliance	Disaster Preparedness training was completed and verified in training logs.
Universal Precautions / Communicable Diseases / Infection Control / Bloodborne Pathogens Part I & II	Compliance	Universal Precautions, Communicable Diseases, Infection Control, and Bloodborne Pathogens Parts I & II training were completed and documented.
CPR/First Aid (By CPR Certified Instructor)	Exception	One of the six reviewed files included documentation of CPR/First Aid training completed outside of the required time frame.
Video Camera Surveillance & Equipment	Compliance	Staff (with access to video system) completed Video Camera Surveillance and Equipment training prior to shift assignment.
CINS/FINS Core	Compliance	CINS/FINS Core training was completed and verified.
Crisis Intervention [e.g., MAB (2-day/16 hours)]	Compliance	Crisis Intervention training (e.g., MAB or FN-approved equivalent) was completed and documented.
Florida Network Youth Suicide Prevention	Exception	One of the six reviewed files did not include documentation of Florida Network Youth Suicide Prevention training completion and excluded any notation in the tracker/file.
Adolescent Development / Positive Youth Development	Exception	Two of the six reviewed files did not include documentation of Adolescent Development and Positive Youth Development training completion and excluded any notation in the tracker/file.
Cultural Humility/Diversity	Exception	One of the six reviewed files did not include documentation of Cultural Humility and Diversity training completion, and one was documented completed outside the required timeframe; neither files/tracker included any additional notation.
Mental Health and Substance Abuse	Compliance	Mental Health and Substance Abuse training was completed and documented in the staff record.
Skill Pro Required Trainings:		

Child Abuse: Recognition, Reporting and Prevention	Exception	One of the six reviewed files documented Child Abuse: Recognition, Reporting, and Prevention training was completed outside the required timeframe and did not include notation in the tracker/file.
Equal Employment Opportunity	Exception	One of the six file reviewed documented Equal Employment Opportunity training was completed outside the required timeframe and did not include notation in the tracker/file.
Human Trafficking Intervention for Direct Care Staff	Exception	One of the six file reviewed documented Human Trafficking Intervention for Direct Care Staff training was completed outside the required timeframe and did not include notation in the tracker/file.
Information Security Awareness	Exception	One of the six file reviewed documented Information Security Awareness training was completed outside the required timeframe and did not include notation in the tracker/file.
Prison Rape Elimination Act (PREA) - Part 1	Exception	One of the six file reviewed documented Prison Rape Elimination Act (PREA) – Part 1 training was completed outside the required timeframe and did not include notation in the tracker/file.
Prison Rape Elimination Act (PREA) - Part 2	Exception	One of the six file reviewed documented Prison Rape Elimination Act (PREA) – Part 2 training was completed outside the required timeframe and did not include notation in the tracker/file.
Sexual Harassment	Exception	One of the six file reviewed documented Sexual Harassment training was completed outside the required timeframe and did not include notation in the tracker/file.
Trauma Responsive Practices	Exception	One of the six file reviewed documented Trauma Responsive Practices training was completed outside the required timeframe, and one was not completed, and both did not include notation in the tracker/file.
Additional FL Network Required Trainings:		
Naloxone Training	Exception	Three of the reviewed six files for Naloxone training were not completed and did not include any notation in the tracker/file.
Adverse Childhood Experiences (ACEs) (Required for All Staff not completing NIRVANA)	Compliance	Adverse Childhood Experiences (ACEs) training was completed by all staff not participating in NIRVANA® training.
FL Statute 984 CINS Petition Training (Case Staffing & CINS Petition Staff Only)	Not Applicable	None of the training files reviewed required FL Statute 984 CINS Petition Training.
Statewide Lockout Protocol	Exception	Neither of the two reviewed applicable files for Statewide Lockout Protocol training were completed and did not include a notation in the tracker/file.
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 training files reviewed required JJIS training.
JJIS Alerts – Part 1 (JJIS Data Entry Staff prior to accessing JJIS)	Compliance	JJIS Data Entry staff completed JJIS Alerts – Part 1 training before accessing JJIS.
JJIS Alerts – Part 2 (JJIS Data Entry Staff prior to accessing JJIS)	Compliance	JJIS Data Entry staff completed JJIS Alerts – Part 2 training before accessing JJIS.
Motivational Interviewing (MI) (Prior to NIRVANA training for Staff who Administer the NIRVANA)	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)	Exception	Two of the three applicable reviewed files documented the completion of the NIRVANA training prior to administering the assessment to youth, and one staff is scheduled to complete the training on 4/22/26, out of compliance with the policy requirements.
Medication Distribution for Shelter Staff Without a Medical License (Prior to administration of medication and annually)	Compliance	Shelter staff without a medical license completed Medication Distribution training prior to administering medication and renewed annually.
PYXIS (Authorized Shelter Staff prior to accessing Pyxis system)	Compliance	Authorized shelter staff completed PYXIS training prior to accessing the Pyxis system.
SNAP Support Overview *This training does not certify staff to facilitate SNAP After completing training, this Supporter must only be paired with a fully trained SNAP Facilitator	Not Applicable	None of the training files reviewed required SNAP Support Training.
SNAP Facilitator Training (Required for All Staff prior to the delivery of Groups)	Not Applicable	None of the training files reviewed required SNAP Facilitator Training.
NetMIS Training (For NetMIS Users prior to accessing NetMIS)	Compliance	NetMIS users completed NetMIS training prior to being granted system access.

<p>NON-LICENSED CLINICAL STAFF ONLY</p> <p>Staff Suicide Assessment Training</p> <p>** 20 hours including a minimum of five (5) one-to-one assessments of suicide risk in the physical presence of a licensed professional. This training is documented and maintained in the staff person's personnel file using the Documentation of Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk form. (Required for All shelter staff who are not licensed prior to independent assessment of suicide risk)</p>	Exception	<p>None of the applicable files included documentation of completing the required 20 hours of Suicide Assessment training and five supervised one-to-one assessments under a licensed professional.</p>
<p>NON-LICENSED CLINICAL STAFF ONLY</p> <p>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)</p> <p>* Prior to working with youth*</p>	Compliance	<p>Non-licensed clinical staff are in progress of completing and documenting 16 hours of clinical training and 36 hours of topic-specific training prior to working independently with youth.</p>
<p>NON-LICENSED CLINICAL STAFF ONLY</p> <p>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)</p> <p>*To be completed during first year of employment*</p>	Compliance	<p>One applicable Bachelor's-level non-licensed counseling staff is in progress of completing mental-health and substance-related coursework within the first year of employment.</p>
<p>For any trainings that are NOT completed within the required timeframe, includes documentation of the reason and scheduled completion date.</p>	Compliance	<p>The shelter manager and clinical director are responsible of notation and documentation of staff training file.</p>
<p>Direct Care staff (full-time, part-time, and on-call) complete all pre-service requirements prior to working independently and achieve a minimum of 80 hours of training during their first year.</p>	Compliance	<p>Direct-care staff are in progress of completing all pre-service requirements prior to working independently and achieved at least 80 hours of training within their first year.</p>
<p>If there was a break in employment for less than six (6) months, the file contains documentation confirming the supervisor reviewed applicable prior training and verified completion.</p>	Exception	<p>The one applicable reviewed file did not contain documentation of a staff review.</p>
<p>If the agency finds that the instructor is not available for the instructor led course within the required timeframe, then document attempts in the staff training file.</p>	Not Applicable	<p>There was no evidence of instructor led courses not being available in the required timeframe.</p>
<p>The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.</p>	Compliance	<p>The agency has the shelter manager and clinical director as responsible for managing employee training files and routinely reviews them to ensure compliance. The organization hired a state-wide trainer to support programs within the state.</p>
<p>All Network-required training is supported by documentation such as certificates, sign-in sheets, and agendas.</p>	Compliance	<p>All Network-required trainings are supported by appropriate documentation, including certificates, sign-in sheets, and training agendas.</p>
Annual Training		
<p>Trainings that are required by the Network must be documented in each individual training file or employee file as well as captured on the FLN Training Log or similar document with the minimum requirements (i.e. Staff Name & Position, Date of Hire, Training anniversary used by agency (calendar, date of hire or fiscal), Training Name, Training Hours, Training Completion or Facilitation Date, Location of Training or Platform Used (when virtual), and Cumulative Total Training Hours)</p>	Compliance	<p>Network-required trainings are documented in individual staff files and recorded in Relias with all required details, including staff information, training hours, completion dates, and cumulative totals. Relias will be updated to accurately reflect all required trainings and deadlines.</p>

Child Abuse: Recognition, Reporting, and Prevention (Annually)	Exception	Three of the six reviewed files documented completion of Child Abuse: Recognition, Reporting, and Prevention training and documented in staff training records.
Human Trafficking Intervention for Direct-Care Staff (Annually)	Exception	Two of the five applicable reviewed files documented completion of Human Trafficking Intervention for Direct-Care Staff training and supported by required documentation.
Information Security Awareness (Annually)	Exception	Four of the six reviewed files documented completion of Information Security Awareness training and documented in staff training records.
It's All About Reporting	Exception	Two of the six reviewed files completed It's All About Reporting and notated in the tracker/file. This is a newly added course, which will be updated in Relias for all staff.
Prison Rape Elimination Act (PREA) Part 1 (Every 2 years)	Exception	Three of the six reviewed files documented completion of Prison Rape Elimination Act (PREA) Part 1 training.
Prison Rape Elimination Act (PREA) Part 2 (Every 2 years)	Exception	Three of the six reviewed files documented completion of Prison Rape Elimination Act (PREA) Part 2 training.
Sexual Harassment (Every 2 Years)	Exception	Four of the six reviewed files documented completion of Sexual Harassment training.
Trauma Responsive Practices (Every 2 Years)	Exception	Three of the six reviewed files documented completion of Trauma Responsive Practices training.
FL Network Annual Required Trainings REQUIRED for Staff Over 1 year		
Florida Network Youth Suicide Prevention (Required Annually)	Exception	Two of the six reviewed files documented completion of Florida Network Youth Suicide Prevention training.
CPR (Every 2 Years - Check for current validity)	Exception	Five of the six reviewed files documented the updated and active CPR certification in accordance with Network requirements.
First Aid (Every 2 Years - Check for current validity)	Exception	Five of the six reviewed files documented the updated and active First Aid certification in accordance with Network requirements.
Crisis Intervention training approved by the Network (ex: Managing Aggressive Behavior (MAB) (Every 2 Years)	Compliance	All applicable staff completed Managing Aggressive Behavior training in accordance with Network policies.
In-Person Fire Safety Equipment (Every 2 years)	Exception	Two of the six reviewed files documented completion of Fire Safety Equipment training.
Virtual Fire Safety Equipment (Every 2 years)	Exception	Two of the six reviewed files documented completion of Virtual Fire Safety Equipment training.
Medication Distribution for Staff Without a Medical License (Re-certification annually)	Compliance	All applicable staff completed Medication Distribution training.
SNAP Refresher Training (Annually for all staff who have completed SNAP Facilitator Training and are delivering SNAP group services or monitoring fidelity)	Not Applicable	None of the training files reviewed required SNAP Refresher training.
For missed trainings, documentation includes the reason for delay and scheduled completion timeline.	Exception	Files reviewed did not include documentation or notation for delay and/or incompletion status and anticipated completion date. The shelter manager updated this process during the review to include a document in the file that includes notation, staff signature, and date.
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	Although staff are receiving ongoing training, as documented in meeting notes, emails, and sign-in sheets, it is not reflected in Relias or staff training tracker/training plan for direct-care Community Counseling.
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	Although direct-care Shelter staff are receiving ongoing training, as evident in other documentation, staff training trackers do not reflect the full total of all completed trainings. The shelter manager has updated the documentation to accurately reflect total completed hours for all trainings.
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 fiscal year cycle.
All Network-required training is supported by documentation such as certificates, sign-in sheets, and agendas.	Compliance	All Network-required trainings are supported by documentation such as certificates, sign-in sheets, and training agendas.
1.5 - Data Entry & Collection		Satisfactory
		Yes

Provider has a written policy and procedure that meets the requirement for Indicator 1.5		1.05 Data Entry/Analyzing and Reporting Information last revised and approved by Regional Director, Shelter Manager and Clinical Director on 3/10/2026.
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
Data sources Reviewed		Dates Reviewed
Managers Meeting Minutes, LSF Quality Improvement Plan and CQI Meeting Minutes, BOD Minutes, Interview with Clinical Director		Oct 2025-March 2026
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 program conducts detailed Peer Reviews of Community Counseling files monthly, however there is no summary of findings provided. Peer Reviews of shelter files have not been conducted since mid October 2025.
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
Supervisors complete a weekly review of transport documentation and provide written feedback or coaching when deficiencies are found.		Approved on 12-9-25 and reviewed on 3-10-26 by Regional Director, Shelter Services Manager and Clinical Director.
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
Provider has a written policy and procedure that meets the requirement for Indicator 1.8		Yes
		Policy 1.08 Youth Contact was last revised on 3/10/2026 and approved by the Regional Director, Shelter Services Manager, and Clinical Director
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
		Policy 1.07 Outreach Services reviewed 11/12/2024 and revised/approved 3/1/2026 by Regional Director, Shelter Services Manager, Clinical Director.
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
		Yes
Provider has a written policy and procedure that meets the requirement for Indicator 3.2		Policy 2.01 Screening and Intake was last revised on 10/9/2025 and approved by the Regional Director, Shelter Services Manager, and Clinical Director
A total of ten file(s) were reviewed during this evaluation period. Of these, four were open and six were closed. Among the open file(s), two residential (RES) and two community counseling file(s) were reviewed. Among the closed file(s), three residential (RES) and three community counseling file(s) were reviewed.		
The screening form is completed immediately for all inquiries into shelter placement.	Compliance	For all inquiries into shelter placement, screening forms were completed immediately by trained staff, ensuring timely assessment and appropriate service placement.
<u>For Community Counseling Services:</u> The initial screening for eligibility for Community Counseling Services (including screening for eligibility, crisis counseling and information, and referral) occurs within 3 business days of referral by a trained staff member using, at minimum, the Florida Network screening form.	Compliance	Initial screenings for Community Counseling Services were completed within three business days of referral by trained staff using the Florida Network screening form. All eligibility, crisis, and referral requirements were met.
Youth and parents/guardians receive the following in writing		
Youth and parents/guardians are provided available service options in writing.	Compliance	Youth and parents/guardians were provided written information outlining all available service options, ensuring informed decision-making about participation.
Youth and parents/guardians are provided "Rights and Responsibilities of Youth" in writing.	Compliance	Written materials detailing the rights and responsibilities of youth were provided at intake, and documentation confirmed receipt in all reviewed files.
Parents/guardians are provided "Rights and Responsibilities of Parents" and/or parent brochure.	Compliance	Parents and guardians were provided the "Rights and Responsibilities of Parents" brochure at intake, and signed acknowledgment forms were present in all records.
The following is also available to the youth and parents/guardians:		
Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication).	Compliance	Youth and parents/guardians received written information describing possible outcomes and actions that may occur through involvement with CINS/FINS services, including case staffing, petitions, and adjudications.
Youth and parents/guardians are provided information regarding the programs grievance procedures.	Compliance	All youth and parents/guardians were informed of the program's grievance procedures, and documentation confirmed this information was reviewed and acknowledged.
If the youth and family do NOT participate in services, the reason is documented on the screening form and logged in NetMIS.	Not Applicable	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
		Yes
Provider has a written policy and procedure that meets the requirement for Indicator 3.3		Policy 2.02 Network Inventory of Risk, Victories And NIRVANA (NIRVANA) was last revised on 3/10/2026 and approved by the Regional Director, Shelter Services Manager, and Clinical Director
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).	Exception	Three of five Community files were not completed by qualified bachelor's or master's level staff who successfully completed the NIRVANA training. All shelter files compliant.
All completed NIRVANA assessments are entered electronically into the Florida Network Management Information System (NetMIS) within three (3) business days of service commencement.	Exception	Four of five Community files did not have completed NIRVANA Assessments entered into NetMIS within three business days of service commencement, ensuring timely data submission and compliance with reporting standards. Two were within 7 business days, one was in 9 business days, the one was entered in 69 business days. All shelter files compliant.

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	Eight of ten total files had Supervisor signature documented after the 7-day window. Timelines include 9, 12, 13, 14, 25, 86, 90, and 176 business days between assessment completion and Supervisor signature.
(Shelter only) NIRVANA Self-Assessment Report (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	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	Three of file Community files were applicable to receive NIRVANA Re-Assessments at 90 days within services but only had NIRVANA Post-Assessments completed at discharge.
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		Yes
		Policy 2.04 Case Management and Service Delivery was last revised on 3/9/2026 and Policy 2.05 Counseling Services was last revised on 3/10/2026. Both were approved by the Regional Director, Shelter Services Manager, and Clinical Director
Each client is assigned a Counselor.	Compliance	Each client was assigned a qualified counselor responsible for coordinating services and maintaining consistent therapeutic engagement.
The following is also available to the youth and parents/guardians:		
In the Shelter Program: Counseling services are provided to each client at least once per week, for the first 12 weeks of services, by a licensed mental health professional or non-licensed staff with clinical experience or has completed the required clinical training working under the direct supervision of a licensed staff member.	Compliance	In the Shelter Program, individual and/or family counseling sessions were provided at least once per week by a licensed mental health provider or by unlicensed staff under the supervision of a licensed clinician.
Community Counseling Program: Counseling services are provided to each client at least once per week, for the first 12 weeks of services, by a licensed mental health professional or nonlicensed staff working under the direct supervision of a licensed staff. <i>(May include Individual, group, and family counseling, Crisis intervention, Parent training, Community-based mental health and substance abuse referrals, Case management, Prevention and diversion services, Skills training, tutorial/remedial services, Vocational, job training, or employment services, and Recreational services)</i>	Exception	In the Community Counseling Program, counseling sessions were not documented as being offered weekly for five of five reviewed files.
The reason(s) why a required weekly session could not be provided is documented in the youth's file and in NetMIS.	Exception	When a required weekly session was not conducted, the reason was not clearly documented for five of five Community files reviewed cases in both the youth's file and NetMIS, including any barriers to participation. All shelter files in compliance.
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/Counselor establishes appropriate referrals to services.	Compliance	Case Manager/Counselor established appropriate community referrals and coordinated follow-up services to address the youth's individual needs.
All counseling and case management sessions are documented in the youth's file and NetMIS, including the reason for missed sessions.	Exception	Five of five Community files reviewed did not have all counseling and case management sessions documented in the youth's file and entered into NetMIS, including explanations for any missed sessions. All shelter files compliant.
If mental health or substance abuse needs, outside of the program's capacity, are identified appropriate referrals are made and documented.	Compliance	When mental health or substance abuse issues outside program capacity were identified, appropriate referrals were made to external providers and fully documented.
For youth receiving Respite Services (DV, Probation & PDC): A minimum of one family counseling session is offered to address reunification planning and related concerns. If the session is not conducted, the reason is documented in the youth's case file, including any barriers to participation or service delivery.	Compliance	Youth receiving Respite Services receive a minimum of one family counseling session to address family reunification planning. If the session could not be provided, the reason and any barrier to the family's participation are documented in the file.

Clients that do not receive services for 30 days or more have their case closed.	Exception	Three of five Community files indicated a period greater than 30 days of no services without file closure. All shelter files in compliance.
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	Direct supervision logs document monthly staff supervision as opposed to weekly supervision. Shelter Supervision notes include more frequent file reviews occurring every week outside of logged monthly supervision.
3.5 - Adjudication Services: Case Staffing		Not Applicable
Provider has a written policy and procedure that meets the requirement for Indicator 3.5		Yes Policy 2.06 Adjudication/Petition Process was last revised on 3/18/2026 and approved by the Regional Director, Shelter Services Manager, and Clinical Director
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	No case staffing committee meetings were scheduled or completed during FY 25/26 to review.
Each case staffing must be recorded in NetMIS within the case, noting the date it occurred.	Not Applicable	No case staffing committee meetings were scheduled or completed during FY 25/26 to review.
The case staffing is convened within 7 days (excluding weekends and legal holidays) of the parent/guardian request.	Not Applicable	No case staffing committee meetings were scheduled or completed during FY 25/26 to review.
Notification to the committee is sent no less than 5 working days prior to the staffing date.	Not Applicable	No case staffing committee meetings were scheduled or completed during FY 25/26 to review.
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	No case staffing committee meetings were scheduled or completed during FY 25/26 to review.
As a result of the case staffing committee meeting, the youth and family are provided a new or revised plan for services.	Not Applicable	No case staffing committee meetings were scheduled or completed during FY 25/26 to review.
At a minimum, the case staffing is attended by:		
Local school district representative	Not Applicable	No case staffing committee meetings were scheduled or completed during FY 25/26 to review.
DJJ rep. or CINS/FINS provider	Not Applicable	No case staffing committee meetings were scheduled or completed during FY 25/26 to review.
Other members may include:		
State Attorney's Office	Not Applicable	No case staffing committee meetings were scheduled or completed to review.
Mental health treatment representative	Not Applicable	No case staffing committee meetings were scheduled or completed to review.
Substance abuse treatment representative	Not Applicable	No case staffing committee meetings were scheduled or completed to review.
Law enforcement representative	Not Applicable	No case staffing committee meetings were scheduled or completed to review.
DCF representative	Not Applicable	No case staffing committee meetings were scheduled or completed to review.
Others requested by youth/family	Not Applicable	No case staffing committee meetings were scheduled or completed to review.
The program has an established case staffing committee and has regular communication with committee members.	Not Applicable	No case staffing committee meetings were scheduled or completed to review.
The program has an established case staffing committee, and has regular communication with committee members.	Not Applicable	No case staffing committee meetings were scheduled or completed to review.
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 3/18/2026 and approved by the Regional Director, Shelter Services Manager, and Clinical Director
If applicable, the program works with the circuit court for judicial intervention for the youth/family, as applicable, including required attendance at all court hearings without subpoena.	Not Applicable	No case staffing committee meetings were scheduled or completed during FY 25/26 to review.
The Case Manager/Counselor completes a review summary prior to the court hearing for a youth.	Not Applicable	No case staffing committee meetings were scheduled or completed during FY 25/26 to review.
3.7 - Service Plan		Satisfactory with Exception/s
		Yes

Provider has a written policy and procedure that meets the requirement for Indicator 3.7		Policy 2.03 Case/Service Plans was last revised on 3/10/2026 and approved by the Regional Director, Shelter Services Manager, and Clinical Director
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	Two of five Community files did not have youth signature present on plans, confirming their participation and agreement with the identified goals and services. All shelter files in compliance.
The signature of the parent/guardian is documented in the service plan.	Exception	One of five Community files did not have parent/guardian signature obtained, reflecting engagement and shared responsibility in the service planning process. All shelter files in compliance.
If unavailable, the absence is documented with a reason on the plan.	Compliance	When a parent/guardian signature is unavailable, the absence is clearly documented with a stated reason, maintaining transparency and compliance.
The signature of the counselor is documented in the service plan.	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	Eight of ten reviewed files did not include the LMHP's signature within seven days of completion. Timelines include 12, 14, 17, 19, 20, 26, 86, 92 business days between service plan completion and Supervisor signature.
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	Four of five Community files were eligible for a 90-day review and one of four eligible files had a 30-day review completed 1 day past the due date. All shelter files in compliance.
At, 60 Days, following plan initiation.	Compliance	The Case/Service Plan is reviewed at 60 days with the youth and parent/guardian, reflecting continued collaboration and responsiveness to evolving needs.
At, 90 Days, following plan initiation.	Exception	Three of five Community files were eligible for a 90-day review and three of three eligible files did not have a 90-day review completed. No eligible shelter files.
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	The agency did not have any applicable court ordered youth with files to review.
3.8 - Youth Records		Satisfactory
		Yes
Provider has a written policy and procedure that meets the requirement for Indicator 3.8		Policy 2.7 Youth Records was last revised on 10/1/2025 and approved by the Regional Director,

		Shelter Services Manager, and Clinical Director
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
		Yes
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 3/10/2026 and approved by the Regional Director, Shelter Services Manager, and Clinical Director
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.	Compliance	For youth referred 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, the 30 and 60 day follow-ups verify school attendance if the youth is subject to compulsory education. Efforts to obtain verification are documented in the youth's file.
Domain Five		
5.0 - Shelter Program Services		Satisfactory
		Yes
Provider has a written policy and procedure that meets the requirement for Indicator 5.0		3.02 Program Orientation 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.	Compliance	Psychoeducational groups are conducted a minimum of five days per week and follow a structured group process model. Each group has a clearly identified leader or facilitator. Group documentation is complete and consistently includes the date and time of the session, length of the group, topic addressed, and a list of participants.
Formal and accessible grievance procedures for youth, including available grievance forms and a locked box, are accessible to youth in a common area.	Compliance	Formal and accessible grievance procedures are in place for youth, including the availability of grievance forms and a locked grievance box located in a common area.
Grievance boxes are checked at least once daily, excluding weekends and holidays) by a member of management or a designated supervisor. Each check is logged in the program's daily logbook, including the date, time, and name of the person conducting the check.	Compliance	Grievance boxes are checked at least once daily, excluding weekends and holidays, by management or a designated supervisor. Each review is documented in the daily logbook with the date, time, and reviewer's name, demonstrating compliance.

Only the Program Director/Supervisor has access to and manages grievances unless it is toward themselves (which is escalated to higher leadership).	Compliance	Only the Program Director or Supervisor has access to and manages submitted grievances, unless the grievance concerns them, in which case it is escalated to higher leadership.
All grievances are resolved and documented by the Program Director within 72 hours. If this does NOT occur within the 72-hour period, there is sufficient documentation explaining the cause of the delay in resolution.	Compliance	All grievances are reviewed, resolved, and documented by the Program Director within 72 hours, with documentation provided for any delays beyond that timeframe.
Grievances are maintained on file for a minimum of one (1) year.	Compliance	Grievances are securely maintained on file for a minimum of one (1) year in accordance with program policy.
Additional Comments:		
5.1 Shelter Environment		Satisfactory
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.	Compliance	The facility remains free of any insect infestation.
All bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, mildew and in good working order.	Compliance	Bathrooms and shower areas are clean, fully functional, odor-free, and maintained to high sanitary standards.
There is no graffiti on walls, doors, or windows.	Compliance	No graffiti or defacement is present on any walls, doors, or windows.
Lighting is adequate for tasks performed there.	Compliance	Lighting is sufficient and appropriate for all activities and workspaces.
Exterior areas are free of debris.	Compliance	Exterior areas are clear of debris and well-kept.
Grounds are free of hazards.	Compliance	Grounds are regularly inspected and free of hazards.
Dumpster and garbage can(s) are covered.	Compliance	Dumpsters and garbage cans are securely covered and properly maintained.
All doors are secure.	Compliance	All facility doors are secure and functioning properly.
In and out access is limited to staff members and key control is in compliance.	Compliance	Access to and from the facility is restricted to authorized staff, and key control procedures are followed in compliance with policy.
All agency and staff vehicles are locked. All agency vehicles are equipped with major safety equipment including first aid kit (with current, non-expired items that are replaced regularly), a fire extinguisher, a flashlight, a glass breaker, and seat belt cutter.	Compliance	All agency and staff vehicles remain locked when not in use and are equipped with required safety gear, including a stocked first-aid kit, fire extinguisher, flashlight, glass breaker, and seatbelt cutter.
Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted.	Compliance	Required postings—including evacuation maps, client rules, grievance procedures, abuse hotline numbers, and DJJ incident reporting information—are clearly displayed and accessible.
Agency has a current DCF Child Care License which is displayed in the facility.	Compliance	The current DCF Child Care License is valid and visibly posted in the facility.
Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects (e.g. cords, rope, metal shower rings).	Compliance	Interior spaces are free from contraband or hazardous unauthorized materials, including metal or foreign objects.
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.	Compliance	All chemicals are properly listed, approved, stored securely, and inventoried both perpetually and through weekly verification; inventories are accurate and current across all storage areas.
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.	Compliance	Fire drills are conducted monthly on each shift, consistently demonstrating safe evacuation within two minutes.
Completes 1 mock emergency drill per shift quarterly, at a minimum.	Compliance	Mock emergency drills are held at least quarterly per shift, ensuring staff readiness and procedural compliance.
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, has 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.	Compliance	Cold and dry food items are properly labeled, dated, and stored; pantry and storage areas are clean and organized.
Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.	Compliance	Refrigerators and freezers are clean, maintain required temperatures, and all appliances are operational and sanitary.
Additional Comments: The program will be undergoing significant renovations of the kitchen, dining room and youth living areas and is currently in the permitting process.		
5.2 - Shelter Search Policy	Satisfactory	
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.	Compliance	Shelter staff perform frequent and random searches during each shift to maintain a secure and controlled environment.
Additional Comments: The reviewer observed two team members conducting a proper contraband search in accordance with policy. One staff member instructed the youth to empty their pockets, remove their shoes and socks, untuck and shake their shirt, and lift each pant leg while continuing to scan the youth with a security wand. Simultaneously, the second staff member searched the youth's school backpack to ensure no contraband was brought into the facility.		
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 Logbooks approved 03/26 by Regional Director, Shelter Manager, Quality Manager	
Data sources Reviewed	Dates Reviewed	Logbook Format

Electronic Logbook	3/1/2026 - 3/14/2026 2/1/2026 - 2/14/2026 1/10/2026- 1/24/2026 12/10/2025 - 12/24/2025 11/10/2005 - 11/24/2025 10/3/2025 - 10/17/2025	Electronic Logbook
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.	Compliance	At the beginning of each shift, the oncoming supervisor and shelter counselor review prior log entries and document the review with a dated and signed entry.
All direct care staff reviews the logbook at the beginning of each shift for the previous two shifts (at minimum) and include the dates reviewed, which is evidenced by the date and their signature at time of entry.	Exception	Over the past six months, electronic logbook entries show staff signed in but did not consistently document review of the previous two shifts, as required by policy. The presence of both compliant and non-compliant sign-in options has contributed to inconsistent usage. The Program Coordinator will submit a work order to Notepad IT to remove the incorrect option and ensure compliance moving forward.
Program director or designee reviews the facility logbook(s) every week and makes a note chronologically indicating dates reviewed and if any corrections, recommendations and follow-up is required, which is evidenced by the date and their signature at time of entry.	Compliance	The program director or designee reviews the facility logbook weekly, documenting the review with the date, signature, and any necessary follow-up or recommendations.
Supervision and resident counts are documented.	Compliance	Supervision and resident counts are consistently documented.
Visitation and home visits are documented.	Compliance	Visitation and home visits are clearly documented.
Additional Comments:		
5.4 - Staffing Standards and Enhanced Supervision		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 5.4		Yes
		3.06 Staffing and Youth Supervision approved 03/26 by Regional Director, Shelter Manager, Quality Manager
Program maintains minimum staffing ratios as required by Florida Administrative Code and contract. 1 staff to 6 youth during awake hours and 1 to 5 youth during offsite activities.	Compliance	The program maintains required staffing ratios in accordance with Florida Administrative Code and contract standards, ensuring a minimum of one staff to six youth during awake hours and one staff to five youth during offsite activities.
All shifts consistently maintain a minimum of two (2) staff present. Program staff included in the staff-to-youth ratio includes staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff.	Compliance	All shifts consistently maintain a minimum of two staff members on duty, with staff included in the ratio verified as background-screened and properly trained youth care, supervision, or treatment personnel.
The shelter has implemented policies and procedures to ensure youth safety when being supervised by staff of the opposite sex.	Compliance	The shelter has implemented and follows clear policies and procedures to ensure youth safety when supervised by staff of the opposite sex.
The program staff schedule is provided to staff or posted in a place visible to staff.	Compliance	Staff schedules are provided and/or posted in a visible location to ensure adequate coverage and awareness of staffing assignments.

There is a holdover overtime rotation roster that includes home telephone numbers of staff who may be available when additional coverage is needed.	Compliance	A holdover and overtime rotation roster is maintained and includes contact information for staff available to provide additional coverage as needed.
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction. Times are documented in real time. (The times do not supersede requirements for constant supervision of youth at risk of suicide.)	Compliance	Staff observe youth at least every fifteen (15) minutes while in sleeping rooms, including during sleep periods, illness, or room restriction, with all checks documented in real time.
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	This section is Not Applicable, as no youth were placed on Enhanced Supervision during the past six months. Therefore, there were no staff assignments or related documentation required in the shelter log or staff calendar.
Additional Comments: Note: At the time of the QI Review, "Enhanced Supervision" was not addressed within the program's policy. Revised version was provided on 4/1/26 by Regional Director SE.		
5.5 - Behavior Management Strategies		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 5.5		Yes
A Behavior Management Strategy (BMS) is in place:		3.05 Behavior Management Strategies approved 03/26 by Regional Director, Shelter Manager, Quality Manager
The program has a detailed written description of the BMS and it is explained during program orientation.	Compliance	The program maintains a detailed written description of its Behavior Management Strategy (BMS), which is reviewed with youth during program orientation.
The written description of the behavioral management strategies include:		
A wide variety of positive incentives are used by the program.	Compliance	The written BMS outlines a wide variety of positive incentives used by the program to encourage appropriate behavior.
Appropriate interventions are used by the program to teach youth new behaviors and help youth understand the natural consequences for their actions.	Compliance	The BMS includes appropriate interventions designed to teach youth new skills and help them understand natural consequences for their actions.
Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior.	Compliance	Behavioral interventions are applied immediately, consistently, and proportionate to the severity of the behavior.
The Behavior Management Strategy includes:		
Consequences for violation of program rules are applied logically and consistently.	Compliance	Consequences for violations of program rules are applied logically, consistently, and fairly across all youth.
Program uses a variety of rewards/incentives to encourage participation and completion of the program.	Compliance	The program uses a variety of rewards and incentives to promote participation, engagement, and program completion.
All staff are trained in the theory and practice of administering BMS rewards and consequences.	Compliance	All staff are trained in both the theory and practical application of administering BMS rewards and consequences.
Supervisors are trained to monitor the use of behavioral interventions by their staff to include the use of point-based and level-based interventions, if applicable to the program intervention strategies.	Compliance	Supervisors are trained to monitor staff implementation of behavioral interventions, including point- or level-based systems when applicable.
There is a protocol for providing feedback and evaluation of staff regarding their use of the positive and negative consequences.	Compliance	The program has a clear protocol for providing feedback and evaluation to staff regarding their use of positive and negative consequences.
In general, BMS promotes order, safety, security, respect, fairness, and protection of resident rights.	Compliance	The BMS promotes order, safety, security, respect, fairness, and protection of youth rights throughout the program environment.
BMS provides constructive discipline that encourages youth to meet behavior expectations.	Compliance	The BMS provides constructive discipline that encourages youth to meet and maintain behavioral expectations.
BMS provides for positive reinforcement & recognition; constructive dialogue & peaceful resolution; and minimizes separation of youth from the general population.	Compliance	The BMS emphasizes positive reinforcement, recognition, constructive dialogue, and peaceful conflict resolution while minimizing unnecessary separation from peers.
Disciplinary measures do not deny the youth any of the following: regular meals and snacks, clothing, sleep, physical or mental health services, educational services, exercise, correspondence privileges, or contact with parents/guardians, attorney of record, juvenile probation officer or clergy.	Compliance	Disciplinary measures never deny youth access to meals, clothing, sleep, healthcare, education, exercise, communication privileges, or contact with parents/guardians, attorneys, probation officers, or clergy.

Additional Comments: The program utilizes a wide variety of positive incentives as part of its behavioral reinforcement and level system. Incentives include dining outings, birthday celebrations, movie experiences, special recreational outings, and access to a prize closet where youth may select preferred items. These incentives are used to encourage positive behavior, promote engagement, and support youth progression through the program's level system. The program utilizes a grant awarded by the Police Benevolent Association of Broward County to fund youth activities.

5.6 - Program Orientation	Satisfactory
	Yes
Provider has a written policy and procedure that meets the requirement for Indicator 5.6	3.02 Program Orientation approved 03/26 by Regional Director, Shelter Manager, 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.	Compliance	Youth receive a comprehensive orientation and handbook within the first 24 hours of admission in accordance with program policy.
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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
	Yes
Provider has a written policy and procedure that meets the requirement for Indicator 5.7	3.03 Youth Room Assignment approved 03/26 by Regional Director, Shelter Manager, Quality Manager

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	Compliance	Initial interactions and staff observations of the youth are used to inform room assignments and supervision levels.
Separation of younger youth from older youth	Compliance	Younger youth are housed separately from older youth to promote safety and developmental appropriateness.
Separation of violent youth from non-violent youth	Compliance	Youth with a history of violent behavior are separated from non-violent youth to reduce risk and maintain safety.
Identification of youth susceptible to victimization	Compliance	Youth identified as susceptible to victimization are assigned rooms that promote protection and increased supervision.
Presence of medical, mental, or physical disabilities	Compliance	Youth with medical, mental health, or physical disabilities are appropriately classified to ensure their needs are safely accommodated.
Suicide risk	Compliance	Youth are screened for suicide risk upon admission, and any identified concerns are addressed immediately through safety planning and supervision.

Sexually aggressive and predatory behavior	Compliance	Youth exhibiting sexually aggressive or predatory behaviors are identified and separated to maintain the safety of others.
Acute health symptoms requiring quarantine or isolation	Compliance	Youth presenting acute health symptoms are appropriately quarantined or isolated in accordance with health and safety protocols.
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors.	Compliance	Alerts are immediately entered into the program's alert system for youth with special needs or risks, including suicide risk, mental health, substance abuse, medical, or security concerns.
Additional Comments:		
5.8 - Video Surveillance		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 5.8		Yes
		3.07 Video Surveillance System approved 03/26 by Regional Director, Shelter Manager, Quality Manager
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.	Compliance	Supervisory review of surveillance footage is conducted at least once every 14 days, with review periods and findings documented in the facility logbook, including random samples of overnight shifts.
Requests for video recordings pursuant to investigations or quality improvement visits are provided within 24-72 hours of the request.	Compliance	The agency has a policy that video recordings requested for investigations or quality improvement purposes are provided within 24-72 hours of the request.
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. There is evidence that all efforts made to obtain repairs are documented and maintained.	Compliance	Service requests for malfunctioning or inoperable cameras are submitted within 24 hours of discovery, and documentation of repair efforts is maintained for quality assurance.
Additional Comments: This reviewer monitored the video surveillance system on 10 separate dates/times within the past 30 days to verify that bed checks were completed in accordance with agency policy and procedures. The dates and times reviewed are as follows: March 3, 2026 (1:00 AM – 3:00 AM), March 8, 2026 (12:00 AM – 2:00 AM), March 11, 2026 (2:00 AM – 4:00 AM), March 14, 2026 (3:00 AM – 5:00 AM), March 17, 2026 (2:00 AM – 4:00 AM), March 19, 2026 (3:00 AM – 5:00 AM), March 22, 2026 (1:00 AM – 3:00 AM), March 25, 2026 (3:00 AM – 5:00 AM), March 27, 2026 (1:00 AM – 4:00 AM), March 29, 2026 (12:00 AM – 3:00 AM). Bed checks were observed to be completed consistently and in accordance with agency policy and procedures during all reviewed timeframes.		
Domain Six		
6.0 - Medication Management and Distribution		Satisfactory
		Yes

Provider has a written policy and procedure that meets the requirement for Indicator 6.0		Policy # 4.03, Medications Administration was reviewed 7/1/2024 and revised/approved on 3/10/2026 by Regional Director, Shelter Services Manager, and Clinical Director.
A total of three Medication Management and distribution files were 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	The program has not had a medication error since October 2024. The RN attends the monthly staff meeting to provide on going training, provides frequent opportunities for staff to practice and shadow the RN, and provides "cheat sheets" for potentially confusing prescriptions. Training is not conducted all at one time, but in digestable bites (controlled Meds, proper documentation, psychotropic medications, Epi-pen training, Pyxis System, 6 rights of med admin, Narcan training, effective handwashing techniques, et...).
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	The program has not had a medication error since October 2024, therefore no current staff providing medication administration have 3 medication errors.
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.

<p>Pyxis machine stored in accordance with guidelines in Florida Statute 499.0121 and policy section Medication Management.</p> <p>FS 499.0121 states the establishment where medications are stored must:</p> <p>(a) Be of suitable size and construction to facilitate cleaning, maintenance, and proper operations;</p> <p>(b) Have storage areas designed to provide adequate lighting, ventilation, temperature, sanitation, humidity, space, equipment, and security conditions;</p> <p>(c) Have a quarantine area for storage of prescription drugs that are outdated, damaged, deteriorated, misbranded, or adulterated, or that are in immediate or sealed, secondary containers that have been opened;</p> <p>(d) Be maintained in a clean and orderly condition; and</p> <p>(e) Be free from infestation by insects, rodents, birds, or vermin of any kind.</p>	Compliance	<p>The Pyxis machine and medication storage area meet all conditions outlined in Florida Statute 499.0121, ensuring cleanliness, security, proper ventilation, temperature control, and pest-free conditions.</p>
<p>Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station.</p>	Compliance	<p>The agency maintains a minimum of two site-specific Pyxis ES System Managers to ensure continuous oversight and accountability.</p>
<p>Oral medications are stored separately from injectable or topical medications.</p>	Compliance	<p>Oral medications are stored separately from injectable and topical medications to prevent cross-contamination.</p>
<p>Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose.</p>	Compliance	<p>Medications requiring refrigeration are stored in a secure, designated refrigerator or within a secured room inaccessible to youth.</p>
<p>Temperature requirements are 2-8 degrees C or 36-46 degrees F for storage of medications.</p>	Compliance	<p>Medication refrigeration units are consistently maintained at 2-8°C (36-46°F) to meet temperature requirements.</p>
<p>Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics).</p>	Compliance	<p>Only authorized staff listed in User Permissions have access to secured medications, with restricted access to controlled substances.</p>
<p>Perpetual inventory with running balances are maintained for controlled substances.</p>	Compliance	<p>Controlled substances are tracked through a perpetual inventory system maintaining real-time running balances.</p>
<p>Shift-to-shift counts (verified by a witness and is documented) are conducted and documented for controlled substances.</p>	Compliance	<p>Shift-to-shift counts of controlled substances are conducted and documented by two staff members to ensure accuracy and accountability.</p>
<p>Non-controlled medication and over-the-counter medications that are accessed regularly are inventoried weekly.</p>	Compliance	<p>Regularly accessed non-controlled and over-the-counter medications are inventoried weekly to ensure proper tracking.</p>
<p>Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly.</p>	Compliance	<p>Syringes and sharps are securely stored, counted, and documented on a weekly basis.</p>
<p>There are monthly reviews of Pyxis Reports to monitor medication management practice.</p>	Compliance	<p>Monthly Pyxis reports are reviewed to monitor medication management practices and identify any trends requiring corrective action.</p>
<p>Medication is verified using one of the three methods outlined in Policy 4.02:</p> <ol style="list-style-type: none"> 1. Contact Pharmacy 2. Registered Nurse or Licensed Practical Nurse 3. Pill Identifier (Pill Finder) – Drugs.com 	Compliance	<p>Medications are verified using approved methods as outlined in Policy 4.02, including contact with the pharmacy, verification by registered or licensed nursing staff, or using a validated pill identifier site by the nurse or trained/certified staff.</p>
<p>When nurse is on duty, medication processes are always conducted by the nurse.</p> <p>If nurse or licensed healthcare staff is not onsite, then the designated staff who has been trained to assist in the self-administration of medication distribution by a licensed Registered Nurse is responsible to provide the medication.</p>	Compliance	<p>When a nurse is on duty, all medication administration processes are conducted by nursing staff; when unavailable, trained and certified staff perform distribution under established procedures.</p>
<p>The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy.</p>	Compliance	<p>The medication delivery process fully aligns with Florida Network's Medication Management and Distribution Policy.</p>
<p>All discrepancies are cleared each shift.</p>	Compliance	<p>All medication discrepancies are identified, reviewed, and cleared at the end of each shift.</p>

Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a) TOP COVER b) BACK PANEL- LEFT TALL CABINET LOCK- LEFT c) BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	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: RN observed (via recording) administering medication to youth. RN observed checking youth's MAR and signing into the Pyxis machine, comparing label on medication bottle to Pyxis machine, dispensing medication to youth with a cup of water, and asking youth to open mouth. Upon completion, RN initiated and provided MAR to youth to initial the administration of medication.		
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 Policy 4.06 Naloxone Policy revised 10/25/25 and reviewed/approved 3/10/2026 by Regional Director, Shelter Services Managers, and Clinical 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:		
6.2 - Suicide Prevention		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 6.2		Yes Policy 4.02 Suicide Assessment was last revised on 3/10/2026 and approved by the Regional Director, Shelter Services Manager, and Clinical Director
A total of six file(s) were reviewed during this evaluation period. Of these two were open and four were closed. Among the open file(s), two community counseling file were reviewed. Among the closed file(s), three 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.	Compliance	Screening results are reviewed, signed by a supervisor, and accurately filed in each youth's case record.
A "yes" to any question triggers a full suicide risk assessment by: 1. A Licensed Mental Health Professional (LMHP), or 2. A non-licensed clinician under direct LMHP supervision.	Compliance	All screens that triggered a positive response for suicide risk demonstrated that a full suicide risk assessment was completed by a qualified LMHP or a clinician under direct LMHP supervision.
Assessment of Suicide Risk must be completed and reviewed by the LMHP within 24 hours of a positive screen.	Compliance	All suicide risk assessments are completed and/or reviewed by an LMHP within 24 hours of a positive screen.
All assessments (initial and follow-up) are documented in detail: youth comments, behaviors, observations, risk indicators, supervision recommendations, treatment/follow-up, and signed and dated by the LMHP.	Compliance	Assessments are thoroughly documented, capturing all relevant observations, youth statements, risk indicators, and follow-up actions, with proper LMHP signature and date. Parents/guardians and program supervisors are notified immediately of any youth at risk, and all contact efforts are well-documented in the case file.

If 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.	Compliance	Parents/guardians and program supervisors are notified immediately of any youth at risk, and all contact efforts are well-documented in the case file.
If a youth poses an immediate threat to self or others at any time, staff follow Baker Act protocols and/or call 911.	Compliance	Staff respond appropriately to any immediate threats by following Baker Act protocols or contacting emergency services as required.
Documentation & Family Notification		
All screenings, assessments, supervision actions, and shift-to-shift handoffs are logged in the daily shelter/counseling logbook.	Compliance	All screenings, assessments, supervision activities, and shift-to-shift handoffs are clearly recorded in the daily logbook.
If a guardian cannot be reached in person, telephone contact attempts are documented; and written notice is sent by certified mail.	Compliance	When guardians cannot be reached directly, all phone attempts are documented, and certified letters are sent as required.
Community Counseling Only: When an immediate assessment is not possible, families receive community resource information.	Compliance	Families receive timely community resource information whenever an immediate assessment cannot be completed.
Community Counseling Only: Any screening conducted on school property during school hours is reported to appropriate school authorities.	Not Applicable	None of the community counseling screenings were conducted on school property.
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.	Compliance	Youth with a positive suicide screen are immediately placed on Constant Sight and Sound Supervision until assessment by a qualified professional occurs.
Residential Only: Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	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.	Compliance	Staff maintain detailed observation logs every 30 minutes, noting time, behavior, warning signs, and initials.
Residential Only: The assigned supervision level remains in place until a follow-up assessment by an LMHP (or supervised unlicensed clinician) confirms safety or the youth is diverted via Baker Act.	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
		Yes
Provider has a written policy and procedure that meets the requirement for Indicator 6.3		Policy 4.01 Healthcare Admission Screening reviewed 11/12/2024 and revised/approved 3/2/2026 by Regional Director, Shelter Services Manager, and Clinical Director.
A total of six Healthcare Admissions Screening file(s) were reviewed during this evaluation period. Of these, two were open and four were closed.		
The primary healthcare screening is completed by the nurse if he/she is present during the intake. If not present during the intake, the nurse reviews the primary healthcare screening within 3 business days.	Exception	The RN review of one of the six healthcare screening records reviewed was three days late, reportedly the RN was on leave at that time. One of six healthcare screening records could not be located in the youth's file or office. The RN was able to show where in the file information was recorded that he routinely obtains during the review of youth healthcare screenings.
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		Satisfactory
		Yes
Provider has a written policy and procedure that meets the requirement for Indicator 6.4		Policy 4.04 Medical and Mental Health Alert Processes reviewed 12/8/23 and revised/approved 3/10/2026 by Regional Director, Shelter Services Manager, and Clinical Director.
A total of six Medical/Mental Health Alert Process file(s) were reviewed during this evaluation period. Of these, three were open and three were closed.		
If youth has a medical or mental health condition or allergies, they are appropriately placed on the program's alert system.	Compliance	Youth with medical or mental health conditions or allergies are appropriately flagged in the program's alert system to ensure staff awareness and safety.
Alert system includes precautions concerning prescribed medications and potential side effects.	Compliance	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.	Compliance	Staff receive clear information and instructions enabling them to recognize and appropriately respond to medical or mental health emergencies.
A medical and mental health alert system is in place that ensure information concerning a youth's medical condition, allergies, common side effects of prescribed medication, foods and medications that are contraindicated, or other pertinent mental health treatment information is communicated to all staff.	Compliance	A comprehensive medical and mental health alert system is in place, ensuring that all relevant information, including allergies, medication contraindications, and treatment considerations, is effectively communicated to all staff.