Agenda Item #: 3FF-1

PALM BEACH COUNTY

BOARD of COUNTY COMMISSIONERS

AGENDA ITEM SUMMARY

Meeting Date: **September 1, 2026** [X] Consent [ ] Regular
[ ] Public Hearing

Department:
Submitted By: County Internal Auditor's Office

I. EXECUTIVE BRIEF

Motion and Title: Staff recommends motion to receive and file:

A. Audit Report #2026-03 Community Services Department – *Gulfstream Goodwill Industries Financial Assistance Agreement. (Audit Work Plan #2024-01); and*

B. Audit Recommendation Follow-up Status Report as of May 15, 2026.

Summary: The County Code requires the County Internal Auditor to submit copies of final audit reports to the Board of County Commissioners (BCC) and the Internal Audit Committee. The County Code also requires the County Internal Auditor to issue semi-annual audit recommendation status reports to the BCC and the Internal Audit Committee. At its Internal Audit Committee meeting held on June 17, 2026, the Committee reviewed the semi-annual audit recommendation status report. The final report for the Community Services Department has been scheduled for review at the September 16, 2026, meeting. We are submitting these reports to the BCC as required by the County Code. **Countywide** (DB)

Background and Justification: County Code Section 2-463(e)(3) requires the County Internal Auditor to submit copies of final audit reports to the BCC and the Internal Audit Committee. County Code Section 2-463(f) requires the County Internal Auditor to submit copies of audit recommendation status reports to the BCC and the Internal Audit Committee. At its Internal Audit Committee meeting held on June 17, 2026, the Committee reviewed the semi-annual audit recommendation status report. The final report for the Community Services Department will be reviewed at the September 16, 2026, meeting. We are submitting these reports to the BCC as required by the County Code.

Attachments:

1. Community Services Department – *Gulfstream Goodwill Industries Financial Assistance Agreement. (Audit Work Plan #2024-01)*
2. Audit Recommendation Follow-up Status Report as of May 15, 2026.

Recommended by: D. D. Z. Digitally signed by David Zamora DC=org, DC=pbcgov, OU=Enterprise, OU=IA, OU=... CN=David Zamora, E=DZamora@pbc.gov I am approving this document with my legally ... Signature Reason: Date: 2026.07.21 15:14:10-04'00' Foxit PDF Editor Version: 12.1.0

County Internal Auditor Date

Recommended by: N/A

County Administrator Date

II. FISCAL IMPACT ANALYSIS

A. Five Year Summary of Fiscal Impact:

Fiscal Years	2026	2027	2028	2029	2030
Capital Expenditures					
Operating Costs					
External Revenues					
Program Income (County)					
In-Kind Match (County)					
NET FISCAL IMPACT	None				
# ADDITIONAL FTE					
POSITIONS (Cumulative)					

Is Item Included In Current Budget? Yes _____ No X
Does this item include the use of federal funds? Yes _____ No X
Budget Account No.: Fund ____ Agency _____ Org. _____ Object _____
Program Number _____ Revenue Source _____

B. Recommended Sources of Funds/Summary of Fiscal Impact:

No fiscal impact

A. Department Fiscal Review:

_____

III. REVIEW COMMENTS:

A. OFMB Fiscal and/or Contract Administration Comments:

7/20/26
Budget/OFMB ~~JA~~ MAT 7/20

7/22/26
Contract Administration ZG 7.22.26

B. Legal Sufficiency:

7/22/26
Assistant County Attorney

C. Other Department Review:

_____
Department Director

This summary is not to be used as a basis for payment.

OFFICE OF THE COUNTY INTERNAL AUDITOR

AUDIT REPORT

Report # 2026-03

AUDIT OF COMMUNITY SERVICES DEPARTMENT

Gulfstream Goodwill Industries Financial Assistance Agreement

TABLE OF CONTENTS

COMMUNITY SERVICES DEPARTMENT (CSD) AUDIT REPORT #2026-03

AUDIT OBJECTIVE AND CONCLUSION

We conducted this audit to determine:

For the period October 1, 2024, through September 30, 2025, did the Community Services Department (CSD) Director ensure the Gulfstream Goodwill Industries (GGI) Financial Assistance Agreement was effectively managed for compliance with contract terms?

As to the audit objective above, we concluded:

Except for the findings and recommendations below, the Community Services Department Director ensured that the Gulfstream Goodwill Industries Financial Assistance Agreement was effectively managed for compliance with contract terms for the period October 1, 2024, through September 30, 2025.

Specifically, we identified opportunities to strengthen monitoring and oversight processes used to evaluate compliance with contract requirements, particularly in the areas of staffing visibility, security staffing oversight, staff training verification, and retention of monitoring documentation supporting contract compliance activities.

Management responded positively to the audit recommendations, and prior to issuance of this report, implemented a number of corrective actions, including revisions to monitoring procedures, supervisory review processes, and monitoring tools. Internal Audit reviewed the documentation provided and will verify the effectiveness of these actions during recommendation follow-up.

FINDINGS AND RECOMMENDATIONS

Finding #1 Homeless Resource Center (HRC) staffing levels were not included in monitoring activities.

Each year, CSD monitoring cycles through one of three approaches:

- *Comprehensive monitoring*, which reviews operations, service delivery, outcomes, and fiscal management
- *Modified monitoring*, which assesses compliance with each contracted scope of work, and
- Service *Delivery monitoring*, which provides a brief review limited to service delivery, outcomes, and fiscal areas.

Staffing levels are important to the HRCs' operations because they support shelter coverage, safety, and service delivery. Because staffing can affect contract performance, periodic review of staffing trends can help management identify operational risks and determine whether planned staffing levels are achieved.

Condition

CSD monitoring activities did not include reviewing staffing levels, staffing trends, or variances between planned and actual staffing at the HRCs.

For FY2025, GGI budgeted and CSD approved 100 full-time positions for coverage across all HRCs. At the start of the 2025 fiscal year, 77 of the positions were filled. GGI hired 38 employees during the year, with 79 of the positions filled at year-end, which resulted in a 46 percent turnover rate.

Because the contract did not specify a required staff-to-guest ratio, we reviewed GGI staffing schedules, vacancies, absences, and payroll records to identify variances between planned and actual staffing levels and to determine whether staffing trends were incorporated into monitoring activities.

We compared staffing shortfalls against on-call coverage through scheduling and payroll to determine whether GGI successfully covered vacancies or absences. When backfill staffing was not available, planned staffing levels were not achieved for those shifts. As a result of staffing vacancies, existing staff were required to work additional hours and extended shifts to maintain operations.

Payroll records also showed extended shifts were common for Housing Technicians (HT) staff, with employees working 16 hours or more at a time to provide coverage. In one instance, an employee worked a 20.50-hour shift, illustrating the operational strain associated with staffing vacancies and absences during the audit period.

During the audit period, staffing records showed vacancies, turnover, extended shifts, and variances between planned and actual staffing levels. For example, of 57 sampled 8-hour shifts reviewed, 18 (32%) did not meet planned staffing levels.

Effect or Risk

Without periodic review of staffing levels and trends, CSD may have limited visibility into ongoing staffing challenges that could affect workload distribution, continuity of services, and contract performance expectations at the HRCs.

Cause
Existing monitoring procedures did not include evaluating staffing levels, staffing trends, or variances between planned and actual staffing at the HRCs.

Criteria
United States Government Accountability Office (GAO) publication entitled, "*Standards for Internal Control in the Federal Government*," require management to design control activities to ensure operations meet objectives and to perform ongoing monitoring to assess whether internal controls operate as intended.

Countywide PPM CW-O-001 entitled "*Policies and Procedures Memoranda (PPMs),*" instructs department and division directors to issue and maintain PPMs that establish policies and procedures for all areas of operation.

The Internal Auditor recommends the following actions:

1. The Department Director should ensure GGI staffing levels and staffing trends at the HRCs are periodically reviewed to identify staffing shortages and determine whether planned staffing levels are being maintained.

2. The Department Director should ensure monitoring procedures are updated to include review of staffing levels, staffing trends, and variances between planned and actual staffing at the HRCs. Updated procedures should be communicated to pertinent staff.

Management Comments and Our Evaluation

Management agreed with the finding and recommendations and indicated that monitoring procedures and tools were revised to require periodic review of staffing levels, staffing trends, and variances between planned and actual staffing at the Homeless Resource Centers (HRCs). Revised procedures, monitoring tools, and supporting documentation were provided.

Based on the information submitted, management has enhanced its monitoring process to improve visibility over staffing levels and trends. Follow-up activities will focus on verifying that the revised process is consistently performed and provides management with sufficient information to monitor contract performance. Accordingly, Recommendations 1 and 2 will remain open for follow-up.

Finding #2 CSD monitoring activities do not consistently verify staff training and certifications.

Condition

CSD reviews GGI staff training and certifications during comprehensive monitoring conducted every three years; however, training and certification records are not reviewed during other monitoring activities conducted between comprehensive monitoring cycles.

In addition, CSD did not retain documentation from the FY2024 comprehensive monitoring for sampled GGI staff training and certification records. As a result, there is no basis for comparison or verification of prior monitoring results.

Of 25 GGI employee records reviewed, six (24%) did not have documentation available demonstrating completion of one or more required training courses or certifications. Among the 19 employees with available records, two (10%) had expired certifications. As shown in Chart 1 below, missing and expired training records occurred across multiple HRC locations, indicating this is not isolated to a single site.

Chart 1

		Y	Y	N	Y	02.23.24	02.23.26	N
		Y	Y	N	Y	12.20.22	12.20.24	Y
		Y	Y	N	Y	01.29.25	01.29.27	N
		Y	Y	N	Y	01.29.25	01.29.27	N
		Y	Y	N	Y	03.31.25	03.31.27	N
		Y	Y	N	Y	04.08.25	04.08.27	N
		Y	Y		Y	01.28.25	01.28.27	N
		Y	Y	N	Y	01.28.25	01.28.27	N
		Y	Y	N	Y	01.08.25	01.08.27	N
		Y	Y	N	Y	01.08.25	01.08.27	N
		Y	Y	N	Y	01.26.23	01.26.25	Y
		Y	Y	N	Y	10.02.24	10.02.26	N
		Y	Y	N	Y	01.28.25	01.28.27	N
		Y	Y	N	Y	07.02.24	07.02.26	N
		Y	Y		Y	08.29.24	08.29.26	N
		Y	Y	N	Y	03.31.25	03.31.27	N
		Y	Y	N	Y	02.08.25	02.08.27	N
		Y	Y		Y	07.02.24	07.02.26	N
		Y	Y	N	Y	01.28.25	01.28.27	N

Effect or Risk

Limited monitoring of GGI staff training records and certifications increases the risk that lapses in requirements are not identified between monitoring cycles.

Without accessible training records, CSD cannot verify GGI staff have met contractual certification requirements, reducing assurance over staff qualifications.

Cause
CSD has not established procedures for collecting and reviewing training records during non-comprehensive monitoring years, reducing its ability to confirm GGI's compliance with training requirements.

Criteria
United States Government Accountability Office (GAO) publication entitled, "*Standards for Internal Control in the Federal Government*," require management to design control activities to ensure operations meet objectives and to perform ongoing monitoring to assess whether internal controls operate as intended.

Countywide PPM CW-O-001 entitled "*Policies and Procedures Memoranda (PPMs),*" instructs department and division directors to issue and maintain PPMs that establish policies and procedures for all areas of operation.

The Internal Auditor recommends the following actions:

3. The Department Director should implement regular, documented reviews of GGI training and certification records in between comprehensive monitoring cycles to ensure ongoing compliance with training requirements.

4. The Department Director should implement written procedures for collecting and reviewing GGI training and certification records in non-comprehensive monitoring years and communicate procedures to pertinent staff.

Management Comments and Our Evaluation

Management agreed with the finding and recommendations and indicated that monitoring procedures were revised to require documented reviews of GGI staff training and certification records during non-comprehensive monitoring years. Revised procedures and monitoring tools supporting these changes were provided.

The revised procedures establish a more structured approach for monitoring training and certification requirements throughout the contract period. Follow-up activities will focus on verifying that these reviews are consistently

performed, documented, and maintained as part of the monitoring process. Accordingly, Recommendations 3 and 4 will remain open for follow-up.

Finding #3 Security staffing monitoring and communication processes could be strengthened.

Post Orders (PO) require two security officers to always be on duty at the HRCs to help ensure safety, to monitor entry points, and to respond to incidents at the sites.

Oversight responsibilities related to security staffing involve multiple parties, including the security contractor, CSD, and Electronic Services and Security (ESS).

Condition
Existing monitoring and communication processes did not consistently verify whether required security staffing levels were maintained at the HRCs.

During our 60-day sample, required staffing levels were met on 47 days (78%) and were below the Post Order requirement on 13 days (22%).

Effect or Risk
Variances from required security staffing levels may limit management's visibility into whether staffing resources are aligned with Post Order requirements and operational needs. Staffing levels below Post Order requirements could reduce the ability to manage conflicts, monitor entry points, and respond to incidents effectively.

Cause
Existing oversight and communication processes were not designed to consistently verify and communicate daily security staffing variances among responsible parties.

Criteria
United States Government Accountability Office (GAO) publication entitled, "*Standards for Internal Control in the Federal Government*," require management to design control activities to ensure operations meet objectives and to perform ongoing monitoring to assess whether internal controls operate as intended.

The Internal Auditor recommends the following actions:

5. The Department Director should ensure security staffing levels at the Homeless Resource Centers are monitored, including comparing levels against contractual requirements.

6. The Department Director should ensure monitoring and oversight procedures are designed to evaluate security staffing levels and identify staffing variances from Post Order requirements.

Management Comments and Our Evaluation

Management agreed with the finding and recommendations and advised that monitoring procedures were revised to require periodic review of security staffing levels against contractual Post Order requirements. Updated procedures and supporting documentation reflecting these changes were provided.

The revised monitoring process is intended to improve oversight of required security staffing levels and communication of staffing variances. Follow-up activities will focus on determining whether security staffing levels are routinely evaluated against Post Order requirements and whether identified variances are appropriately documented and communicated. Accordingly, Recommendations 5 and 6 will remain open for follow-up.

Finding #4 Monitoring documentation not consistently maintained.

The County contracts with GGI to provide shelter services to individuals experiencing homelessness. CSD regularly conducts both fiscal and programmatic monitoring of GGI pursuant to the contract agreement.

Services and Activities Management Information System (SAMIS) is the application used by CSD to document activities for financially assisted agencies, including processing reimbursement requests, tracking agency programs, and storing monitoring documentation.

Condition
CSD did not consistently retain documentation of its FY2025 monitoring of GGI client and staff records and were not available within SAMIS.

Thirteen of the 23 (57%) client worksheets reviewed were not uploaded in SAMIS. Of those thirteen, five were located on an employee's desktop and

eight were not located. As a result, 15 of 23 (65%) worksheets were accessible.

Documentation supporting the training and certification review of GGI employees performed by CSD during its 2024 comprehensive monitoring was not retained.

Effect or Risk
Missing documentation reduces CSD's ability to verify that monitoring procedures were performed and that monitoring results were complete and accurate, which may impact contract compliance oversight.

Cause
Written procedures for retaining monitoring documentation in SAMIS and supervisory review processes are not formalized, resulting in inconsistent documentation retention and storage.

Criteria
PPM CW-O-001 entitled *"Policies and Procedures Memoranda (PPMs),"* instructs department and division directors to issue and maintain PPMs that establish policies and procedures for all areas of operation.

"Florida's General Records Schedule GS1-SL" requires that audit supporting documents created by an agency or organization be retained for five years.

The Internal Auditor recommends the following actions:

7. The Community Services Director should ensure all documentation is maintained to support monitoring of GGI client and staff records.

8. The Community Services Director should implement written procedures to maintain documentation of monitoring activities and establish periodic supervisory reviews to ensure records are complete and accurate. Procedures are to be communicated to staff.

Management Comments and Our Evaluation

Management agreed with the finding and recommendations and indicated that written procedures, monitoring file checklists, supervisory review requirements, and documentation retention practices were revised to strengthen monitoring documentation. Supporting documentation reflecting these changes was also provided.

The revised procedures strengthen expectations for maintaining monitoring documentation and supervisory review of monitoring activities. Recommendation follow-up will verify whether supporting documentation is consistently retained, readily accessible, and maintained in accordance with established procedures. Accordingly, Recommendations 7 and 8 will remain open for follow-up.

OPERATIONAL STRENGTHS

The Community Services Department Director has assembled a team of individuals who demonstrate a strong commitment to their work and the communities they serve. This includes the staff responsible for contract and fiscal monitoring of the GGI contract. The employees display a strong understanding of the programs they monitor and work to ensure service quality and contractual compliance.

The department has also leveraged technology by implementing multiple software applications that improve workflow efficiency and support its partnership with GGI. This commitment to innovation extends to its public website, which is engaging and easy to navigate, offering links that clearly guide users to the wide range of services provided by CSD.

BACKGROUND

The Community Services Department's mission is to promote independence and enhance the quality of life in Palm Beach County by providing effective and essential services to residents in need.

The CSD is comprised of three divisions (Administration, Human Services and Community Action, and Senior and Veteran Services) along with several independent programs.

This audit was included in the 2024 Audit Work Plan approved by the Audit Committee. In the inclusion of Community Services in the work plan, several key factors were considered: length of time since the last audit, volume of funding administered, vulnerable populations served, and alignment with several BCC strategic priorities.

In planning this audit, we reviewed prior audits conducted by external agencies over various CSD programs, which included:

- HIV Programs (Ryan White) - Health and Human Services
- Senior Services Programs - Area Agency on Aging

- Community Action Program Services - Florida Department of Children and Families
- Community Services Block Grants including LIHEAP (Low Income Energy Assistance)- Florida Department of Economic Opportunity
- Continuum of Care (COC) and Client Management and Information System (CMIS)- U. S. Department of Housing and Urban Development

From our evaluation, we determined that the major funding source not recently audited was ad valorem. This funding is used to support key elements of the County's homeless response strategy, including the Homeless Resource Centers. The primary recipient of ad valorem funding for this purpose is Gulfstream Goodwill Industries, which operates the County's three HRCs.

Under Financial Assistance Agreement R2024-1492, Palm Beach County provides approximately $6.98 million annually to Gulfstream Goodwill Industries to operate the County's three Homeless Resource Centers. The three-year agreement totals approximately $20.9 million and supports shelter operations, case management, navigation services, employment counseling, housing referrals, and other services for individuals experiencing homelessness.

The Board of County Commissioners (BCC) has steadily expanded its efforts to address homelessness in Palm Beach County.

In 2012, the BCC approved the concept and funding for the Senator Philip D. Lewis Center, the County's first Homeless Resource Center. In 2018, the BCC adopted the Ten-Year Plan to End Homelessness, which included establishing additional HRCs.

On January 7, 2020, the BCC formally adopted the "Leading the Way Home" plan to end and prevent homelessness, followed by approval of the Sheltering and Housing Strategy Annex (Fairgrounds) on February 25, 2020, which provided housing for individuals living in unsafe conditions.

Palm Beach County currently has an agreement with Gulfstream Goodwill Industries to operate the County's HRCs and to provide core homeless-service functions including emergency shelter, case management, navigation, employment counseling, and housing referrals. All services are available 24/7, year-round. GGI currently operates three HRCs:

HRC-1: Lewis Center
HRC-2: Mid-County Facility
HRC-3: Western Shelters in Belle Glade and Pahokee

GGI is monitored by the County's Community Services Department to ensure fiscal and programmatic accountability, including mandatory insurance and safeguards for appropriate use of funds.

Accordingly, our review focused primarily on the Human Services section of CSD's Division of Human Services and Community Action, which administers services for individuals experiencing homelessness.

In addition, our review included CSD's Administration Division's Contracting and Fiscal sections, which provide program oversight, fiscal monitoring and compliance reviews for all agencies that CSD has a contract.

AUDIT SCOPE AND METHODOLOGY - GENERAL

The scope of the audit covered activities related to CSD's management and oversight of Palm Beach County's Financial Assistance Agreement R2024-1492 with GGI for the period of October 1, 2024, through September 30, 2025. Fieldwork was performed between November 2025 and February 2026.

Our review of CSD monitoring of GGI involved two CSD divisions, the Administration Division, and the Division of Human Services and Community Action.

The methodologies used to meet the audit objective included:

- Meetings with CSD management and interviews with key personnel in Administration, specifically the Fiscal and Contracts section, and Human Services Division personnel associated with the shelter operations.
- Meetings with GGI management and staff to review procedures for case management, staffing, and training.
- Review of Agreement R2024-1492 between the County and GGI as well as relevant state laws, County and Departmental policies and procedures.
- Data analyses of employee schedules, timesheets, payroll and required training and certifications.
- Review of the Contract for Uniformed Security Guard Services and site-specific Post Orders for each HRC.
- Data analysis of each HRC's security detail activity report and any accompanying incident reports.
- Vouching of invoices from various quarters to the general ledger.
- Review of selected files against entries in the Client Management Information System (CMIS) for contract compliance.

AUDIT METHODOLOGY – DETAIL BY AUDIT FINDING

Finding #1
We met with Contract and Fiscal Section management and staff to discuss the process used to verify GGI staffing levels at the HRCs. On sampled dates for each HRC, we compared GGI scheduled staffing to actual staffing to determine if staffing requirements were met through scheduled coverage or on-call staffing, and to identify any gaps.

Finding #2
We discussed CSD monitoring of GGI staff training and certifications with CSD management and staff; and reviewed a sample of GGI employee files to verify training and certifications required by the contract were current and being retained by both GGI and CSD.

Finding #3
We discussed monitoring security levels at the HRCs with CSD management and staff. For a sample of dates at each HRC, we compared HRC site-specific Post Orders to the security contractor's daily reports to identify security staff on duty to verify if required staffing levels were being met.

Finding #4
We met with Contract Section management and staff to discuss the process to select client and staff files for review. We reviewed worksheets to support CSD reviews of client files in CMIS during the period of October 1, 2024, through January 31, 2025, along with the list of GGI employees included in the review. We verified the accuracy of a sample of client files.

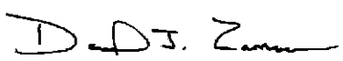
MANAGEMENT AND AUDIT RESPONSIBILITIES

Management is responsible for establishing and maintaining effective internal controls to help ensure that appropriate goals and objectives are met; resources are used effectively, efficiently, and economically, and are safeguarded; laws and regulations are followed; and management and financial information is reliable and properly reported and retained.

Internal Audit is responsible for using professional judgment in establishing the scope and methodology of our work, determining the tests and procedures to perform, conducting the work, and reporting the results.

We conducted this performance audit in accordance with generally accepted government auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a

reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.



David Zamora, CIA, CRMA, CFE, CGAP, CFI
County Internal Auditor
July 13, 2026

Date: 06/25/26
To: David Zamora, County Internal Auditor
From: James Green, Director, Community Services Department
Re: Audit Response, Gulfstream Goodwill Agreement

DS JG

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www.pbc.gov/communityservices

Palm Beach County COMMUNITY SERVICES
Helping People Build Better Communities

MANAGEMENT'S RESPONSE TO THE AUDIT

The Community Services Department appreciates the Internal Auditor's review of the Gulfstream Goodwill Industries Financial Assistance Agreement. Management concurs with the findings and recommendations and has begun identifying changes to strengthen contract-specific monitoring, documentation, and oversight.

During the audit period, CSD was also transitioning its monitoring process to an electronic monitoring workflow within the Services and Activities Management Information System (SAMIS). This transition was intended to centralize monitoring activities, supporting documentation, communications, corrective actions, and approvals. CSD acknowledges that records must remain complete and accessible during periods of process change. The continued implementation of electronic monitoring in SAMIS, together with updated written procedures and supervisory review, is expected to improve file retention, workflow visibility, and consistency in future monitoring cycles.

Finding #1: HRC staffing levels were not included in monitoring activities

Management Response

Management concurs with the finding and recommendations.

CSD agrees that staffing levels and staffing trends should be periodically reviewed when staffing is material to program operations, continuity of services, or contract performance. Although the GGI agreement does not establish a specific staff-to-guest ratio, planned staffing levels, vacancies, turnover, extended shifts, and differences between planned and actual coverage provide important information regarding operational capacity.

CSD will update its monitoring procedures to require staff to review each agreement, scope of work, approved budget, and material programmatic and operational requirements when developing the monitoring tool. For the GGI agreement, the monitoring process will include periodic review of staffing levels, vacancies, turnover, staffing trends, and significant variances between planned and actual staffing.

The monitoring documentation will identify the records reviewed, the results of the review, any material staffing concerns, and any follow-up or corrective action required.

Corrective Actions

1. Revise monitoring procedures to require consideration of contract-specific staffing and operational requirements.
2. Update the GGI monitoring tool to include review of staffing levels, staffing trends, vacancies, turnover, and variances between planned and actual staffing.
3. Establish a process for documenting and communicating material staffing concerns to appropriate CSD and agency management.
4. Communicate the revised procedures to applicable monitoring and program staff.

Responsible Parties: Contract Manager Michael Wright and Division of Human Services Director Wendy Tippett
Status: complete

Finding #2: CSD monitoring activities do not consistently verify staff training and certifications
Management Response
Management concurs with the finding and recommendations.

CSD agrees that required staff training and certifications should be periodically reviewed and documented when they are included in the agreement or are material to service delivery and program operations. CSD's prior monitoring approach reviewed training and certification records during comprehensive monitoring. Management acknowledges that this approach did not provide documented verification during the years between comprehensive monitoring cycles.

CSD will revise its procedures to require documented review of applicable training, licensure, and certification requirements during non-comprehensive monitoring years. The frequency and extent of the review will be based on the contractual requirements, expiration periods, program risk, and monitoring approach.

For the GGI agreement, CSD will establish a process to periodically obtain and review documentation supporting required staff training and certifications. Identified missing or expired records will be communicated to GGI for follow-up and corrective action, as appropriate.

Corrective Actions

1. Identify the GGI training and certification requirements that must be reviewed between comprehensive monitoring cycles.
2. Establish a documented process for collecting and reviewing applicable training and certification records during non-comprehensive monitoring years.
3. Update the monitoring tool to document the sample reviewed, expiration dates, exceptions identified, and required follow-up.
4. Communicate the revised procedures to applicable monitoring and program staff.

Responsible Parties: Contract Manager Michael Wright and Division of Human Services Director Wendy Tippett
Status: complete

Finding #3: Security staffing monitoring and communication processes could be strengthened
Management Response
Management concurs with the finding and recommendations.

CSD agrees that security staffing at the Homeless Resource Centers should be periodically compared with applicable Post Order requirements and that identified variances should be communicated to the appropriate responsible parties.
Security staffing oversight involves coordination among CSD, Electronic Services and Security, the security contractor, and GGI. CSD will work with the applicable parties to clarify the information to be provided, the frequency of review, responsibility for evaluating staffing variances, and the process for documenting and escalating identified concerns.

The GGI monitoring tool and related oversight procedures will be updated to include review of security staffing against applicable Post Order requirements. Monitoring documentation will identify the records reviewed, exceptions noted, communications made, and any required follow-up.

Corrective Actions

1. Coordinate with Electronic Services and Security and other responsible parties to clarify roles related to security staffing oversight.
2. Establish a process for periodically comparing actual security staffing with applicable Post Order requirements.
3. Define how staffing variances will be documented, communicated, escalated, and resolved.
4. Incorporate security staffing review into the GGI monitoring tool and applicable oversight procedures.
5. Communicate the revised process to applicable staff and responsible parties.

Responsible Parties: Director of Finance and Support Services Julie Dowe and Director of Human Services Wendy Tippett
Status: complete

Finding #4: Monitoring documentation was not consistently maintained
Management Response
Management concurs with the finding and recommendations.

During the audit period, CSD was transitioning from its prior monitoring process to an electronic monitoring workflow within SAMIS. As part of this transition, monitoring activities and supporting records were maintained in more than one location, and expectations for uploading all supporting documentation and completing supervisory file reviews had not yet been fully formalized. Management acknowledges that this contributed to inconsistent retention and accessibility of certain monitoring records.

CSD will formalize written procedures specifying the monitoring documentation that must be retained in SAMIS or another approved centralized repository. The procedures will address monitoring worksheets, sample selections, supporting records, communications, corrective actions, monitoring results, and evidence of supervisory review.

CSD will also establish a monitoring file checklist and require a documented completeness review before monitoring activities are closed. Continued implementation of the electronic SAMIS monitoring process will provide a more centralized record of monitoring activities and improve document retention, workflow tracking, management visibility, and consistency across monitoring cycles.

Corrective Actions

1. Develop written procedures identifying the documentation that must be retained for each monitoring review.
2. Require monitoring records and supporting documentation to be stored in SAMIS or another approved centralized repository.
3. Implement a standardized monitoring file checklist.
4. Require supervisory review of monitoring files for completeness and accuracy before monitoring is closed.
5. Provide training to applicable staff on documentation, retention, and supervisory review requirements.
6. Continue implementation and refinement of the electronic SAMIS monitoring workflow to support centralized recordkeeping and oversight.

Responsible Parties: Contract Manager Michael Wright
Status: complete

Conclusion

CSD will use the audit results to strengthen its monitoring framework while recognizing that monitoring activities must be tailored to the requirements, risks, and operating model of each agreement. The corrective actions will establish clearer documentation requirements, strengthen supervisory review, and ensure that monitoring tools address material fiscal, programmatic, and operational requirements.

Office of the County Internal Auditor

AUDIT RECOMMENDATION STATUS
FOLLOW-UP REPORT
AS OF MAY 15, 2026

ISSUED MAY 16, 2026

Stewardship – Accountability – Transparency

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May 16, 2026

TO: The Audit Committee

FROM: David A.J. Zamora, Internal Auditor

SUBJECT: Audit Recommendation Status Follow-Up Report Dated May 15, 2026

The Audit Recommendation Status Follow-Up Report providing the status of audit recommendations as of May 15, 2026 is attached. These status reports are prepared semiannually for periods ending on the 15th of May and November. The reports are submitted to the Audit Committee at its meeting following the report "as of" dates. We will submit the reports to the BCC (generally January and July) following Audit Committee review.

The report contains a Summary Status of Audit Recommendations followed by:

- Exhibit 1 Audit Recommendations Open at the Beginning of and Issued During the November 16, 2025 through May 15, 2026 Reporting Period
- Exhibit 2 Open Audit Recommendations by County Department as of May 15, 2026
- Exhibit 3 Summary Aging of Open Audit Recommendations as of May 15, 2026
- Exhibit 4 Recommendation Status as of May 15, 2026
- Exhibit 5 Open Recommendation Risk Rankings as of May 15, 2026
- Exhibit 6 Open Recommendation Risk Urgency/Importance Pie Chart as of May 15, 2026
- Exhibit 7 Open Recommendation Risk Level Pie Chart as of May 15, 2026
- Exhibit 8 Open Recommendation Risk Ranking by Department – Bar Graph as of May 15, 2026

The purpose of this report is to keep the Audit Committee, the BCC, and County Administration informed of the status of recommendations made by the Internal Auditor's Office and to facilitate oversight by County Administration on departmental implementation activities.

Exhibit 4 highlights recommendations which have had final management action without correcting the underlying condition where we believe additional action is necessary (highlighted purple) or that have been open for at least two years (highlighted yellow).

Audit recommendation follow-up is conducted to determine if management has implemented the corrective action agreed to during the audit and to ensure the underlying condition has been corrected. Audit recommendations are proposed by the Internal Auditor's Office and either accepted by management as proposed or management proposes alternate solutions, which are acceptable to Internal Audit. An audit recommendation is "Open" from the time the audit report containing the recommendation has been issued by Internal Audit until management has either implemented the recommendation or decided to take no further action. Audit recommendations remain in this report as long as the recommendation is open. If management chooses to take no further action, Internal Audit reports that in Exhibit 4 and recommends appropriate action to the Audit Committee.

This report tracks every audit recommendation from the date of issuance through to final disposition. Management establishes projected implementation dates for all recommendations during the audit. Internal Audit tracks the projected implementation dates and conducts follow-up on audit recommendations when management confirms the recommendation has been implemented.

If management has not implemented the recommendation by the scheduled implementation date, Internal Audit makes inquiries of management to determine:

- What actions, if any, have been taken by management;
- Why the recommendation has not been implemented as scheduled; and
- When will the recommendation be implemented?

Internal Audit will conduct limited due diligence reviews to determine the validity of management's responses and consult with County Administration to determine if the reasons for delay are reasonable and report delinquencies where appropriate. The recommendation implementation date will be adjusted as necessary based on the new information from management.

Recommendation status is listed in Exhibit 4 as either:

➢ **Completed** The recommendation has been fully implemented or management has implemented alternative actions that achieved the same purpose as the original recommendation, and the actions taken by management have corrected the underlying conditions. Internal Audit review confirms management's actions.

➢ **In process** Internal Audit has conducted a follow-up review and found that management has not fully implemented the recommendation and that additional work is necessary to fully implement the recommendation. Management provides a new projected implementation date for the corrective action. Additional follow-up will be required. In some cases, management tells Internal Audit that implementation is underway but not yet complete. In that case Internal Audit will perform limited procedures to verify management's assertion.

➢ **Future implementation** The implementation date established by management occurs after the date of this report and Internal Audit has done no review work on the recommendation.

➢ **Follow-up pending** The department has reported implementation of the audit recommendation. However, Internal Audit has not yet done the follow-up review work to confirm management's actions.

PALM BEACH COUNTY AUDIT COMMITTEE

JUNE 17, 2026

RECOMMENDATION STATUS REPORT

EXHIBIT 1

Exhibit 1: Audit Recommendation Activity This Reporting Period

Report		Report Issue Date	Number of Open Audit Recommendations Beginning of Reporting Period	Number of Audit Recommendations Issued this Reporting Period	Final Management Action Taken During Reporting Period	Number of Open Audit Recommendations End of Reporting Period
23-03	**Information Systems Services** Countywide IT Systems Access Controls Audit	Feb-23	12		4	8
23-04	**Facilities Development & Operations** Electronic Services & Security - Contractors & After-hours	Feb-23	1		0	1
24-02	**Housing and Economic Development** Mortgage and Housing Investments Division - Pre-Award and Post-Award Grant Monitoring	Jul-24	1		1	0
24-03	**Office of Equal Business Opportunity** New Ordinance Implementation	Jul-24	5		4	1
25-02	**Housing and Economic Development** Grant Monitoring of Community Development Block Grant (CDBG) Awarded Funding Contracts	Jan-25	4		4	0
25-05	**Human Resources** Performance Management Audit	Aug-25	12		0	12
26-02	**Countywide** Personally Identifiable Information (PII) Audit	Apr-26		4	3	1
Totals			**35**	**4**	**16**	**23**

PALM BEACH COUNTY AUDIT COMMITTEE

JUNE 17, 2026

RECOMMENDATION STATUS REPORT

EXHIBIT 2

Exhibit 2: Open Audit Recommendations by County Department as of May 15, 2026

Department	In Process	Future Implementation
Countywide PII	0	1
Housing and Economic Development	1	0
Human Resources	8	4
Facilities Development and Operations	1	0
Information Systems Services	8	0
Total Open Recommendations	**18**	**5**

Future implementation
The implementation date established by management occurs after the date of this report and Internal Audit has done no review work on the recommendation(s).

PALM BEACH COUNTY AUDIT COMMITTEE

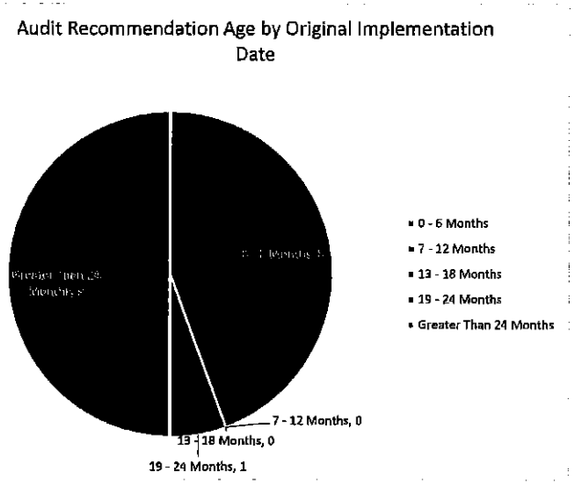
JUNE 17, 2026

RECOMMENDATION STATUS REPORT

EXHIBIT 3

Exhibit 3
Aging of Open Audit Recommendations by Original Implementation Date
As of May 15, 2026

Timeframe	Open at the End of this Period	In Process	Future Implementation
0 - 6 Months	13	8	5
7 - 12 Months	0	0	0
13 - 18 Months	0	0	0
19 - 24 Months	1	1	0
Greater Than 24 Months	9	9	0
Total	**23**	**18**	**5**



	Original Implementation Dates for Individual Recommendations
0 - 6 Months	November 16, 2025 through May 15, 2026
7 - 12 Months	May 16, 2025 through November 15, 2025
13 - 18 Months	November 16, 2024 through May 15, 2025
19 - 24 Months	May 16, 2024 through November 15, 2024
Over 24 Months	May 15, 2024 and earlier

Future Implementation: The implementation date established by management occurs after the date of this report and Internal Audit has done no review work on the recommendation(s).

PALM BEACH COUNTY AUDIT COMMITTEE

JUNE 17, 2026

RECOMMENDATION STATUS REPORT

EXHIBIT 4

Exhibit 4 - Recommendation Status at May 15, 2026

Audit Report Number, Title and Recommendation(s)	Recommendation Status

[redacted] = *Final management action taken without resolving underlying condition.*
Yellow highlight = Recommendations open over 2 years past original implementation date.

23-03 Information Systems Services Countywide IT Systems Access Controls	
Report issued February 13, 2023 containing 18 recommendations. *Follow-up #1 February 28, 2025; 12 remain open.* *Follow-up #2 April 30, 2026; 8 remain open.*	
1. Departments should deprovision an employee's SIM account immediately upon termination. Original implementation date: June 2023 Revised implementation date: September 2025	**Status – May 2026** **In process.** 44% of employee SIM accounts were not deprovisioned within one business day of termination. **Status – November 2025** **In process.** Follow-up #2 in process.
2. The ISS Department should train departmental SIM Administrators on the PPM deprovisioning requirements, and on the capabilities of SIM (Centralize Directory) to support them. Original implementation date: June 2023 Revised implementation date: September 2025	**Status – May 2026** **In process.** 50% of departments for a 2-month period did not deprovision user access within one business day of termination. **Status – November 2025** **In process.** Follow-up #2 in process.
3. Departments should deprovision SIM accounts immediately utilizing one of the available direct methods. Original implementation date: June 2023 Revised implementation date: September 2025	**Status – May 2026** **In process.** 14% of departments did not use an available direct method to remove user access. **Status – November 2025** **In process.** Follow-up #2 in process.
4. The ISS Department should develop and provide training to all SIM Administrators on deprovisioning user access, which includes the available methods to disable a user's SIM	**Status – May 2026** **In process.** All SIM Administrators do not use a direct method to deprovision user access within the

Exhibit 4 - Recommendation Status at May 15, 2026

Audit Report Number, Title and Recommendation(s)	Recommendation Status
account within the required timeframe. Original implementation date: June 2023 Revised implementation date: September 2025	required timeframe. **Status – November 2025** **In process.** Follow-up #2 in process.
5. Department SIM Administrators (or staff tasked to remove user access) should be informed of employee terminations prior to the effective date. Original implementation date: June 2023 Revised implementation date: September 2025	**Status – May 2026** **In process.** Two departments did not ensure their SIM Administrator was notified of employee terminations before the effective date. **Status – November 2025** **In process.** Follow-up #2 in process.
6. Departments should develop procedures to ensure SIM Administrators are informed of employee terminations prior to their effective date. Original implementation date: June 2023 Revised implementation date: September 2025	**Status – May 2026** **In process.** Two departments did not have procedures to ensure employee terminations are communicated to staff responsible for removing access. **Status – November 2025** **In process.** Follow-up #2 in process.
7. Departments should disable terminated employee SIM accounts when required. Original implementation date: March 2023 Revised implementation date: September 2025	**Status – May 2026** **Closed.** Due to OTI policy - OTI is in the process of implementing a new Identity Management system (IBM Verify) to replace the SIM identity management platform currently in use. **Status – November 2025** **In process.** Follow-up #2 in process.
9. Departments with students/seasonal employees should temporarily disable (login restricted) their system access as of their last day of seasonal work, and immediately	**Status – May 2026** **In process.** Departments did not disable system access for seasonal employees on their last workday or

Exhibit 4 - Recommendation Status at May 15, 2026

Audit Report Number, Title and Recommendation(s)	Recommendation Status
when they terminate. Original implementation date: June 2023 Revised implementation date: September 2025	immediately upon termination. **Status – November 2025** **In process.** Follow-up #2 in process.
11. Departments should immediately deprovision external users that no longer need access. Original implementation date: March 2023 Revised implementation date: September 2025	**Status – May 2026** **Completed.** **Status – November 2025** **In process.** Follow-up #2 in process.
12. Departments should develop/implement procedures to ensure access for external users are deprovisioned as required when no longer needed. Procedures should include regular monitoring of external user access needs, and setting up external user accounts in SIM (centralized directory) with an expiration date. Original implementation date: March 2023 Revised implementation date: September 2025	**Status – May 2026** **In process.** One department of 11 did not deprovision external user access when required and does not have procedures for removing external users. **Status – November 2025** **In process.** Follow-up #2 in process.
17. Department procedures should ensure user access to department-controlled applications are deprovisioned when required. Original implementation date: June 2023 Revised implementation date: September 2025	**Status – May 2026** **Completed.** **Status – November 2025** **In process.** Follow-up #2 in process.
18. Departments should develop and implement procedures that ensure user access to department-controlled applications are deprovisioned within the required timeframe. Original implementation date:	**Status – May 2026** **Completed.** **Status – November 2025** **In process.** Follow-up #2 in process.

Exhibit 4 - Recommendation Status at May 15, 2026

Audit Report Number, Title and Recommendation(s)	Recommendation Status
June 2023 Revised implementation date: September 2025	
23-04 Facilities Development & Operations Electronic Services & Security – Access Section: Contractors & After-hours	
Report issued February 16, 2023 containing 10 recommendations. *Follow-up #1 April 4, 2025; 3 remain open.* *Follow-up #2 July 11, 2025; 1 remains open.*	
9. The ESS Director should review and update policies to ensure they match the relevant processes. Original implementation date: August 2023 Revised implementation date: June 2025 October 2025	**Status – May 2026** **In process.** Follow-up #3 assignment pending. *ESS was recently moved from the FDO Department to the Public Safety Department.* **Status – November 2025** **In process.** Two of four PPMs were determined be updated and approved as a result of the first follow-up review. While the remaining two PPMs CW-L-007 and FCO-038 (last updated in June 2015) have been updated and are in draft, they have not yet been formally approved. The delay in approval is related to the ongoing committee review and recent leadership transitions affecting the approval process.
24-02 Housing and Economic Development: Mortgage and Housing Investments Division - Pre-Award and Post-Award Grant Monitoring	
Report issued July 12, 2024 containing 6 recommendations. *Follow-up #1 May 15, 2025; 4 remain open.* *Follow-up #2 October 30, 2025; 1 remains open.* *Follow-up #3 April 30, 2026; all recommendations implemented.*	
3. Department Director should ensure that	**Status – May 2026**

Exhibit 4 - Recommendation Status at May 15, 2026

Audit Report Number, Title and Recommendation(s)	Recommendation Status
ARCs are requested and obtained from all active mortgage recipients. In addition, this should include: • Request timely notification by other HED divisions of mortgage events that would nullify an ARC requirement, • Educating staff on the significance of obtaining an ARC, • Enacting random spot-checks for changes of ownership in Palm Beach County PAPA website, and • Review of recipients' files to ensure receipt of ARCs. Original implementation date: July 2024 Revised implementation date: December 2025	**Completed.** **Status – November 2025** **In process.** Standard Operating Procedures (SOPs) for issuing ARC notifications have been updated and staff training has been provided, but the procedures implemented have not yet resulted in ARCs being obtained from all active mortgage recipients
24-03 Office of Equal Business Opportunity – New Ordinance Implementation	
Report issued July 16, 2024 containing 18 recommendations. *Follow-up #1 April 8, 2025; 5 remain open.* *Follow-up #2 May 7, 2026; 1 remains open.*	
1. The Department Director should ensure reported participation payment information is supported to confirm accuracy and completeness. More specifically: • Overall reported totals match corresponding total supporting payment details, • Reported categorical subtotal amounts match corresponding subtotals in the report's summary attachment, and Construction departments reported totals match corresponding department totals in the supporting payment details. Original implementation date: July 2024	**Status – May 2026** **Completed.** **Status – November 2025** **In process.** Follow-up #2 in process.

Exhibit 4 - Recommendation Status at May 15, 2026

Audit Report Number, Title and Recommendation(s)	Recommendation Status
Revised implementation date: September 2025	
2. The Department Director should implement procedures to ensure reported totals are accurate and complete, which include: • Reconciling overall totals with corresponding subtotals and supporting payment detail, • Use of hard cut-off dates to capture and report participation data, and Disclosure of variances between reported amounts, subtotal amounts and supporting detail. Original implementation date: July 2024 Revised implementation date: September 2025 August 2026	**Status – May 2026** **In process.** PPM CW-O-043 pending PPM review and approval. *OEBO was recently converted to a Division within the Housing and Economic Development (HED) Department.* **Status – November 2025** **In process.** Follow-up #2 in process.
5. Construction Department Directors should ensure Schedule 2s and 4s are uploaded into the contract management system (eCMS) as required. Original implementation date: December 2024 Revised implementation date: September 2025	**Status – May 2026** **Completed.** **Status – November 2025** **In process.** Follow-up #2 in process.
11. The Department Director should ensure that PII, including social security numbers, is immediately redacted on all application paperwork stored by OEBO. Original implementation date: July 2024 Revised implementation date: April 2026	**Status – May 2026** **Completed.** **Status – November 2025** **In process.** Follow-up #2 in process.
12. The Department Director should develop written procedures on PII redaction and	**Status – May 2026** **Completed.**

Exhibit 4 - Recommendation Status at May 15, 2026

Audit Report Number, Title and Recommendation(s)	Recommendation Status
communicate to staff. These procedures should include: advising applicants to redact unneeded PII from documents before submission to OEBO, and for OEBO management and staff to verify PII is redacted on submitted documents prior to storing. Original implementation date: July 2024 Revised implementation date: April 2025	**Status – November 2025** **In process.** Follow-up #2 in process.
25-02 Housing and Economic Development: Grant Monitoring of Community Development Block Grant (CDBG) Awarded Funding Contracts	
Report issued January 31, 2025 containing 4 recommendations. Department did not agree with recommendations. *Follow-up #1 January 27, 2026; all recommendations completed.*	
1. Department Director should ensure monitoring documentation (Monthly Performance Reports, "On-Site" visits) for subrecipient projects are complete for compliance with the terms of the agreement and HUD requirements. Original implementation date: August 2025	**Status – May 2026** **Completed.** **Status – November 2025** **In process.** Follow-up #1 in process.
2. Department Director should either ensure compliance with terms of subrecipient agreements (obtain monthly performance reports), or revise terms of subrecipient agreements to align with the departments' monitoring efforts (exclude requirement to provide monthly reports). Original implementation date: August 2025	**Status – May 2026** **Completed.** **Status – November 2025** **In process.** Follow-up #1 in process.
3. Department Director should ensure CDBG funded capital projects (including less visible types) are monitored and maintained for the	**Status – May 2026** **Completed.**

Exhibit 4 - Recommendation Status at May 15, 2026

Audit Report Number, Title and Recommendation(s)	Recommendation Status
required five-year period. Original implementation date: August 2025	**Status – November 2025** **In process.** Follow-up #1 in process.
4. Department Director should ensure written procedures are developed (and included in the Department's monitoring handbook) to monitor/maintain less visible CDBG funded capital projects for the five-year period required by HUD. Example of monitoring could include an annual Declaration of Agreement signed to provide written evidence project is being maintained. In addition, ensure pertinent staff are aware of the newly established plan. Original implementation date: August 2025	**Status – May 2026** **Completed.** **Status – November 2025** **In process.** Follow-up #1 in process.
25-05 Human Resources Performance Management Audit	
Report issued August 21, 2025 containing 13 recommendations. Recommendation #4 was completed upon issuance of the report, leaving 12 open recommendations. *Follow-up #1 assignment pending.*	
1. The Department Director should ensure that all existing County job classifications and corresponding compensation levels are reviewed and updated to accurately reflect current duties and responsibilities. Additionally, a formal policy should be implemented to require periodic reviews (e.g., every five years) of all job classifications and pay levels, in accordance with PBC Merit Rules. Original implementation date: March 2026	**Status – May 2026** **In process.** Follow-up assignment pending. **Status – December 2025** **Future Implementation**

Exhibit 4 - Recommendation Status at May 15, 2026

Audit Report Number, Title and Recommendation(s)	Recommendation Status
2. The Department Director should ensure that formal, written scoring guidelines are developed and that staff are trained to apply these consistently during the evaluation of employment applications. Original implementation date: December 2025	**Status – May 2026** **In process.** Follow-up assignment pending. **Status – December 2025** **Future Implementation**
3. The Department Director should implement periodic supervisory reviews or spot checks of application scoring to confirm accuracy, fairness, and consistency across HR staff. Original implementation date: December 2025	**Status – May 2026** **In process.** Follow-up assignment pending. **Status – December 2025** **Future Implementation**
5. The Department Director should ensure that Recruitment and Selection explores ways to improve the visibility and reach of job postings through enhanced outreach strategies, such as broader advertisement, partnerships with local organizations, or targeted campaigns. As part of this effort, the department should consider benchmarking practices used by local municipalities or peer counties with more proactive or innovative recruitment approaches, if data is available. Original implementation date: December 2025	**Status – May 2026** **In process.** Follow-up assignment pending. **Status – December 2025** **Future Implementation**
6. The department Director should begin collecting and recording, when feasible, the reason applicants decline job offers. Original implementation date: December 2025	**Status – May 2026** **In process.** Follow-up assignment pending. **Status – December 2025** **Future Implementation**
7. The Department Director should develop and implement policies and procedures to: • Analyze this information to identify trends and improvement areas. • Share relevant findings with department managers to assist decision-making and corrective actions at the operational level.	**Status – May 2026** **In process.** Follow-up assignment pending. **Status – December 2025** **Future Implementation**

Exhibit 4 - Recommendation Status at May 15, 2026

Audit Report Number, Title and Recommendation(s)	Recommendation Status
Original implementation date: December 2025	
8. The Department Director should develop measurable (SMART) goals and objectives aligned with the primary functions and responsibilities of the R&S section. Original implementation date: March 2026	**Status – May 2026** **In process.** Follow-up assignment pending. **Status – December 2025** **Future Implementation**
9. The Department Director should conduct an annual review of R&S functions and ensure that KPIs remain aligned with core responsibilities, support continuous improvement, and provide meaningful performance insight, consistent with the OFMB's SMART criteria guidance. Original implementation date: March 2026	**Status – May 2026** **In process.** Follow-up assignment pending. **Status – December 2025** **Future Implementation**
10. The Department Director should coordinate with the Information Systems Services (ISS) Department to enhance HRIS functionality to: • Allow departments to edit and resubmit returned NERs, minimizing the need to delete and recreate entries. • Display accurate processing status (e.g., in-process, completed, or filled) to improve transparency and workload management. • Implement a notification within HRIS to remind departments to verify that job specifications are correct before submitting a New Employee Requisition (NER). Original implementation date: June 2026	**Status – May 2026** **In process.** Follow-up assignment pending. **Status – December 2025** **Future Implementation**
11. The Department Director should collaborate with ISS to prioritize and implement necessary HRIS updates to ensure the system continues to align with evolving business needs and supports operational	**Status – May 2026** **In process.** Follow-up assignment pending. **Status – December 2025**

Exhibit 4 - Recommendation Status at May 15, 2026

Audit Report Number, Title and Recommendation(s)	Recommendation Status
efficiency. Original implementation date: June 2026	**Future Implementation**
12. The Department Director should ensure that: • The two outdated R&S PPMs are reviewed and updated to reflect current practices. • The six draft PPMs are finalized and approved, if appropriate. • All finalized R&S PPMs are communicated to staff and made readily accessible. Original implementation date: June 2026	**Status – May 2026** **In process.** Follow-up assignment pending. **Status – December 2025** **Future Implementation**
13. The Department Director should establish procedures requiring periodic review and updating of R&S PPMs, at minimum every five years, or whenever significant operational changes occur, in accordance with Countywide PPM CW-O-001. Original implementation date: June 2026	**Status – May 2026** **In process.** Follow-up assignment pending. **Status – December 2025** **Future Implementation**
26-02 Countywide Personally Identifiable Information (PII) Data Security	
Report issued April 22, 2026 containing 4 recommendations. Recommendations #1, 2, & 4 were completed upon issuance of the report, leaving one open recommendation. *Follow-up #1 assignment pending future implementation dates.*	
3. The County Administrator should ensure that standardized countywide PII data security training is established. Original implementation date: November 2026	**Status – May 2026** **Future Implementation**

PALM BEACH COUNTY AUDIT COMMITTEE

JUNE 17, 2026

RECOMMENDATION STATUS REPORT

EXHIBIT 5

Exhibit 5 definitions & legend

1. By Risk Level

- **High Significance (Critical) – H:**
  - Recommendations that address issues with a high potential to cause severe financial, operational, or reputational damage if not corrected promptly.
  - Examples: Major control deficiencies, compliance violations, fraud risks.
- **Medium Significance (Important) – M:**
  - Recommendations that deal with issues that pose a moderate risk, such as inefficiencies or errors that may impact operations or reporting but are not likely to lead to immediate severe consequences.
  - Examples: Process improvements, moderate compliance concerns, IT system vulnerabilities.
- **Low Significance (Advisory) – L:**
  - Recommendations focused on minor issues with little potential to cause harm. These issues often relate to best practices or optimizations that do not present significant risks.
  - Examples: Enhancements to existing processes, minor inconsistencies in documentation, or low-priority technical recommendations.

2. By Compliance Requirements

- **Regulatory Compliance – R:**
  - Recommendations related to laws, regulations, or mandatory compliance standards.
- **Internal Policies – IP:**
  - Recommendations related to adherence to company policies or internal control procedures.
- **Best Practices – BP:**
  - Recommendations that promote efficiency, effectiveness, or best industry practices but are not strictly required.

3. By Urgency/Importance

- **Immediate Action Required – I:**
  - Recommendations requiring immediate attention and implementation due to their high risk.
- **Short-Term – ST:**
  - Recommendations that should be addressed within a short time frame (e.g., 3-6 months).
- **Long-Term – LT:**
  - Recommendations that can be scheduled for longer-term planning and action (e.g., over 6 months to a year).

Exhibit 5 - Open Recommendation Risk Rankings as of May 15, 2025

Rec #	Department	Report Title	Recommendation Description	Risk Level	Compliance Requirement	Urgency	# of Recs.
1	ISS (Countywide)	Countywide IT Systems Access Controls Audit	1.Departments should deprovision an employee's SIM account immediately upon termination.	High	Internal Policies/Best Practices	Immediate	8
2			2.The ISS Department should train departmental SIM Administrators on the PPM deprovisioning requirements, and on the capabilities of SIM (Centralize Directory) to support them.	Medium	Internal Policies/Best Practices	Short-term	
3			3.Departments should deprovision SIM accounts immediately utilizing one of the available direct methods.	High	Internal Policies/Best Practices	Immediate	
4			4. The ISS Department should develop and provide training to all SIM Administrators on deprovisioning user access, which includes the available methods to disable a user's SIM account within the required timeframe.	Medium	Internal Policies	Short-term	
5			5.Department SIM Administrators (or staff tasked to remove user access) should be informed of employee terminations prior to the effective date.	Medium	Internal Policies/Best Practices	Short-term	
6			6.Departments should develop procedures to ensure SIM Administrators are informed of employee terminations prior to their effective date.	Medium	Internal Policies/Best Practices	Short-term	
9			9. Departments with students/seasonal employees should temporarily disable (login restricted) their system access as of their last day of seasonal work, and immediately when they terminate.	Medium	Internal Policies	Short-term	

Exhibit 5 - Open Recommendation Risk Rankings as of May 15, 2025

Rec #	Department	Report Title	Recommendation Description	Risk Level	Compliance Requirement	Urgency	# of Recs.
12			12. Departments should develop/implement procedures to ensure access for external users are deprovisioned as required when no longer needed. Procedures should include regular monitoring of external user access needs, and setting up external user accounts in SIM(centralized directory) with an expiration date	Medium	Internal Policies/Best Practices	Short-term	
9	Public Safety/ESS	ESS - Access Section - Contractors & After-hours	9.The ESS Director should review and update policies to ensure they match the relevant processes.	Low	Best Practices	Long-term	1
2	HED	OEBO New Ordinance Implementation	2. The Department Director should implement procedures to ensure reported totals are accurate and complete, which include: • Reconciling overall totals with corresponding subtotals and supporting payment detail, • Use of hard cut-off dates to capture and report participation data, and • Disclosure of variances between reported amounts, subtotal amounts and supporting detail.	High	Regulatory	Immediate	1
1	HR	Performance Management Audit	1. The Department Director should ensure that all existing County job classifications and corresponding compensation levels are reviewed and updated to accurately reflect current duties and responsibilities. Additionally, a formal policy should be implemented to require periodic reviews (e.g., every five years) of all job classifications and pay levels, in accordance with PBC Merit Rules.	Medium	Internal Policy	Short-term	12

Exhibit 5 - Open Recommendation Risk Rankings as of May 15, 2025

Rec #	Department	Report Title	Recommendation Description	Risk Level	Compliance Requirement	Urgency	# of Recs.
2	HR	Performance Management Audit	2. The Department Director should ensure that formal, written scoring guidelines are developed and that staff are trained to apply these consistently during the evaluation of employment applications.	Medium	Best Practices	Short-term	
3			3. The Department Director should implement periodic supervisory reviews or spot checks of application scoring to confirm accuracy, fairness, and consistency across HR staff.	Medium	Best Practices	Short-term	
5			5. The Department Director should ensure that Recruitment and Selection explores ways to improve the visibility and reach of job postings through enhanced outreach strategies, such as broader advertisement, partnerships with local organizations, or targeted campaigns. As part of this effort, the department should consider benchmarking practices used by local municipalities or peer counties with more proactive or innovative recruitment approaches, if data is available.	Low	Best Practices	Long-term	
6			6. The department Director should begin collecting and recording, when feasible, the reason applicants decline job offers.	Low	Best Practices	Long-term	
7			7. The Department Director should develop and implement policies and procedures to: •Analyze this information to identify trends and improvement areas. •Share relevant findings with department managers to assist decision-making and corrective actions at the operational level.	Low	Best Practices	Long-term	

Exhibit 5 - Open Recommendation Risk Rankings as of May 15, 2025

Rec #	Department	Report Title	Recommendation Description	Risk Level	Compliance Requirement	Urgency	# of Recs.
8	HR	Performance Management Audit	8. The Department Director should develop measurable (SMART) goals and objectives aligned with the primary functions and responsibilities of the R&S section.	Medium	Internal Policies/Best Practices	Short-term	
9			9. The Department Director should conduct an annual review of R&S functions and ensure that KPIs remain aligned with core responsibilities, support continuous improvement, and provide meaningful performance insight, consistent with the OFMB's SMART criteria guidance.	Medium	Internal Policies/Best Practices	Short-term	
10			10. The Department Director should coordinate with the Information Systems Services (ISS) Department to enhance HRIS functionality to: •Allow departments to edit and resubmit returned NERs, minimizing the need to delete and recreate entries. •Display accurate processing status (e.g., in-process, completed, or filled) to improve transparency and workload management. •Implement a notification within HRIS to remind departments to verify that job specifications are correct before submitting a New Employee Requisition (NER).	Medium	Best Practices	Short-term	
11			11. The Department Director should collaborate with ISS to prioritize and implement necessary HRIS updates to ensure the system continues to align with evolving business needs and supports operational efficiency.	Low	Best Practices	Long-term	

Exhibit 5 - Open Recommendation Risk Rankings as of May 15, 2025

Rec #	Department	Report Title	Recommendation Description	Risk Level	Compliance Requirement	Urgency	# of Recs.
12			12. The Department Director should ensure that: •The two outdated R&S PPMs are reviewed and updated to reflect current practices. •The six draft PPMs are finalized and approved, if appropriate. •All finalized R&S PPMs are communicated to staff and made readily accessible.	Low	Internal Policy	Long-term	
13			13. The Department Director should establish procedures requiring periodic review and updating of R&S PPMs, at minimum every five years, or whenever significant operational changes occur, in accordance with Countywide PPM CW-O-001.	Low	Internal Policy	Long-term	
3	Countywide	Personally Identifiable Information (PII)	3. The County Administrator should ensure that standardized countywide PII data security training is established.	Medium	Internal Policy Best Practices	Short-term	1

PALM BEACH COUNTY AUDIT COMMITTEE

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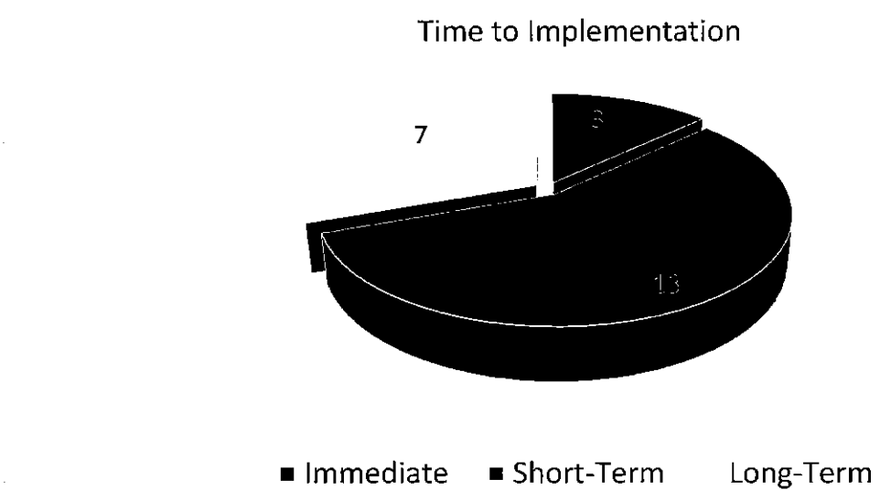
EXHIBIT 6

Exhibit 6 - Open Recommendation Risk Urgency/Importance as of May 15, 2026

Urgency	Number of Open Recommendations
Immediate	3
Short-Term	13
Long-Term	7
TOTAL	23



PALM BEACH COUNTY AUDIT COMMITTEE

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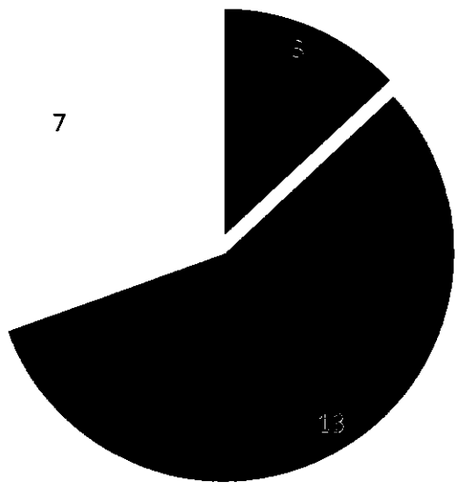
EXHIBIT 7

Exhibit 7 - Open Recommendation Risk Level as of May 15, 2026

Risk Ranking	Number of Open Recommendations
High Risk	3
Medium Risk	13
Low Risk	7
Total:	**23**

Risk Ranking of Open Recommendations



PALM BEACH COUNTY AUDIT COMMITTEE

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RECOMMENDATION STATUS REPORT

EXHIBIT 8

Exhibit 8 - Open Recommendation Risk Ranking by Department – as of May 15, 2026

	Risk Rank			
Department	**High Risk**	**Medium Risk**	**Low Risk**	**TOTAL**
Countywide PII	0	1	0	1
Public Safety/ESS	0	0	1	1
HED - OEBO	1	0	0	1
HR	0	6	6	12
ISS (Countywide)	2	6	0	8
TOTAL	3	13	7	23