STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Melbourne Center for Personal Growth

AMIkids, Inc.
(Contract Provider)
1000 Inspiration Lane
Melbourne, Florida 32934

Review Date(s): February 11 - 14, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

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; or limited, unintentional, and/or non-systemic exceptions which do not result in reduced or substandard service delivery; or systemic exceptions with corrective action already applied and demonstrated.
Limited Compliance	Systemic exceptions to the requirements of the indicator; exceptions to the requirements of the indicator which result in the interruption of service delivery; and/or 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 which typically requires immediate follow-up and response to remediate the issue and ensure service delivery.

Review Team

The Bureau of Monitoring and Quality Improvement wishes to thank the following review team members for their participation in this review, and for promoting continuous improvement and accountability in juvenile justice programs and services in Florida:

Bonita Williams, Office of Program Accountability, Lead Reviewer, Standard 2
Marvin Bliss, Office of Program Accountability, Regional Monitor, Standard 5
Kara Brown, Office of Program Accountability, Regional Monitor, Standard 3
Elizabeth Ham, Kissimmee Youth Academy, Director of Nursing, Standard 4
Peter Keelan, Office of Education, Regional Education Coordinator, Standard 2
Stephanie Lobzun, Office of Program Accountability, Regional Monitor, Standard 3
Amanda Nelson, Office of Program Accountability, Regional Monitor, Standard 1
Tamara Mahl-Adkins, Office of Program Accountability, Regional Monitor, Interviews
Greg MahoumNassar, Office of Program Accountability, Regional Monitor, Standard 2
Kamille Payne, Office of Program Accountability, Regional Monitor, Standard 1 & 5

Program Name: Melbourne Center for Personal Growth	MQI Program Code: 1270
Provider Name: AMIkids, Inc	Contract Number: R2119
Location: Brevard County / Circuit 18	Number of Beds: 32
Review Date(s): February 11 - 14, 2020	Lead Reviewer Code: 148

This review was conducted in accordance with FDJJ-2000 (Contract Management and Program Monitoring and Quality Improvement Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Assessment and Performance Plan, (3) Mental Health and Substance Abuse Services, (4) Health Services, and (5) Safety and Security, which are included in the Residential Standards.

Overall Rating Summary

The following limited and/or failed indicators require immediate corrective action.

Limited Ratings	Failed Ratings
1.08 In-Service Training	3.09 Psychiatric Services *
1.14 Internal Alerts System and Alerts (JJIS)*	5.04 Ten Minute Checks *
2.06 Gang Identification: Prevention and Intervention Activities	5.06 Logbook Entries and Shift Report Review
3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff	5.16 Fire, Safety, and Evacuation Drills
4.15 Medication Management	5.26 Safety Planning Process for Youth
5.17 Disaster and Continuity of Operations Planning (COOP)	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	Initial Background Screening *	Satisfactory
1.02	Five-Year Rescreening	Satisfactory
1.03	Provision of an Abuse-Free Environment *	Satisfactory
1.04	Management Response to Allegations *	Satisfactory
1.05	Incident Reporting (CCC) *	Satisfactory
1.06	Protective Action Response (PAR) and Physical Intervention Rate	Non-Applicable
1.07	Pre-Service/Certification Requirements *	Satisfactory
1.08	In-Service Training	Limited
1.09	Grievance Process	Satisfactory
1.10	Delinquency Intervention and Facilitator Training	Satisfactory
1.11	Life Skills Training Provided to Youth	Satisfactory
1.12	Restorative Justice Awareness for Youth	Satisfactory
1.13	Gender-Specific Programming	Satisfactory
1.14	Internal Alerts System and Alerts (JJIS)*	Limited
1.15	Youth Records (Healthcare and Management)	Satisfactory
1.16	Youth Input	Satisfactory
1.17	Advisory Board	Satisfactory
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory
1.20	Recreation and Leisure Activities	Satisfactory

* The Department has identified certain key critical indicators. These indicators represent critical areas that require immediate attention if a program operates below Department standards. A program must therefore achieve at least a Satisfactory Compliance rating in each of these indicators. Failure to do so will result in a program alert form being completed and distributed to the appropriate program area (detention, residential, probation).

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

Standard 2 - Assessment and Performance Plan		
2.01	Initial Contacts to Parent/Gaurdian and Court Notification	Satisfactory
2.02	Youth Orientation	Satisfactory
2.03	Written Consent of Youth Eighteen or Older	Satisfactory
2.04	Classification Factors, Procedures, and Reassessment for Activities	Satisfactory
2.05	Gang Identification: Notification of Law Enforcement	Satisfactory
2.06	Gang Identification: Prevention and Intervention Activities	Limited
2.07	Residential Assessment for Youth (RAY)	Satisfactory
2.08	Youth Needs Assessment Summary (YNAS)	Satisfactory
2.09	Performance Plan Development, Goals and Transmittal *	Satisfactory
2.10	Performance Plan Revisions	Satisfactory
2.11	Performance Summaries and Transmittals	Satisfactory
2.12	Parent/Guardian Involvement in Case Management Services	Satisfactory
2.13	Members of Treatment Team	Satisfactory
2.14	Incorporation of Other Plans Into Performance Plan	Satisfactory
2.15	Treatment Team Meetings (Formal and Informal Reviews)	Satisfactory
2.16	Career Education	Satisfactory
2.17	Educational Access	Satisfactory
2.18	Education Transitions Plan	Satisfactory
2.19	Transitions Planning, Conference, and Community Re-entry Team Meeting (CRT)	Satisfactory
2.20	Exit Portfolio	Satisfactory
2.21	Exit Conference	Satisfactory

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Standard 3: Mental Health and Substance Abuse Services
Residential Rating Profile

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory
3.02	Licensed Mental Health and Substance Abuse Clinical Staff *	Satisfactory
3.03	Non-Licensed Mental Health and Substance Abuse Clinical Staff	Limited
3.04	Mental Health and Substance Abuse Admission Screening	Satisfactory
3.05	Mental Health and Substance Abuse Assessment/Evaluation	Satisfactory
3.06	Mental Health and Substance Abuse Treatment	Satisfactory
3.07	Treatment and Discharge Planning *	Satisfactory
3.08	Specialized Treatment Services*	Satisfactory
3.09	Psychiatric Services *	Failed
3.10	Suicide Prevention Plan *	Satisfactory
3.11	Suicide Prevention Services *	Satisfactory
3.12	Suicide Precaution Observation Logs *	Satisfactory
3.13	Suicide Prevention Training *	Satisfactory
3.14	Mental Health Crisis Intervention Services *	Satisfactory
3.15	Crisis Assessments *	Satisfactory
3.16	Emergency Mental Health and Substance Abuse Services *	Satisfactory
3.17	Baker and Marchman Acts *	Non-Applicable

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	Designated Health Authority/Designee *	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification/Consent	Satisfactory
4.05	Healthcare Admission & Rescreening Form	Satisfactory
4.06	Youth Orientation to Healthcare Services/Health Education	Satisfactory
4.07	Designated Health Authority/Designee Admission Notification	Satisfactory
4.08	Health-Related History	Satisfactory
4.09	Comprehensive Physical Assessment/TB Screening	Satisfactory
4.10	Sexually Transmitted Infection & HIV Screening	Satisfactory
4.11	Sick Call Process	Satisfactory
4.12	Episodic/First Aid Care/Emergency Care	Satisfactory
4.13	Off-Site Care/Referrals	Satisfactory
4.14	Chronic Illness/Periodic Evaluations	Satisfactory
4.15	Medication Management	Limited
4.16	Medication/Sharps Inventory and Storage Process	Satisfactory
4.17	Infection Control/Exposure Control	Satisfactory
4.18	Prenatal Care/Education	Non-Applicable

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

	Standard 5 - Safety and Security	
5.01	Youth Supervision *	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	Ten Minute Checks *	Failed
5.05	Census, Counts, and Tracking	Satisfactory
5.06	Logbook Entries and Shift Report Review	Failed
5.07	Key Control*	Satisfactory
5.08	Contraband Procedure	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	Vehicals and Maintenance	Satisfactory
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Satisfactory
5.13	Tool Inventory and Mangement	Satisfactory
5.14	Youth Tool Handling and Supervision	Satisfactory
5.15	Outside Contractors	Satisfactory
5.16	Fire, Safety, and Evacuation Drills	Failed
5.17	Disaster and Continuity of Operations Planning (COOP)	Limited
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.19	Youth Handling and Supervison of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.20	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.21	Elements of the Water Safety Plan, Staff Training, and Swim Test *	Satisfactory
5.22	Visitation and Communication	Satisfactory
5.23	Search and Inspection of Controlled Observation Room	Non-Applicable
5.24	Controlled Observation	Non-Applicable
5.25	Controlled Observation Safety Checks and Release Procedures	Non-Applicable
5.26	Safety Planning Process for Youth	Failed

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Program Overview

The Melbourne Center for Personal Growth is a thirty-two bed program, for thirteen to eighteen-year-old males, located in Melbourne, Florida. The program is operated by AMIkids Incorporated, through a contract with the Department. The program provides substance abuse treatment overlay services. In addition, the program fosters youth by providing Aggression Replacement Training, Seven Challenges, and the Council for Boys and Young Men. Additional treatment services provided includes family and individual counseling. Program administration is comprised of an executive director, director of case management, director of operations, director of education, and director of treatment.

Case management services are provided by one case manager and one transition specialist. Mental health staff at the program includes one advance practice registered nurse (APRN), one licensed mental health counselor, and six outreach specialists. Medical services are offered daily and are provided by the designated health authority and three nurses. Educational services are provided by the Brevard County School Board.

The layout of the program includes the dorm, education, and administration buildings. The dorm houses the youth, the education building has three classrooms, as well as the kitchen and cafeteria, and the administration building encompasses the clinic and the mental health staff offices, as well as offices for all of the administrators. The program has thirty-two operating security cameras providing coverage at the time of the annual compliance review. At the time of the annual compliance review, the program had three vacant positions (direct care positions).

Strengths and Innovative Approaches

- The youth had the opportunity to tour the Embraer Customer & Delivery Center, a facility which produces executive jets in Melbourne. Youth were able to learn about jobs in the aviation manufacturing field.

- The executive director, one staff, and youth attended Legislative Day at the Capitol in Tallahassee, Florida. They met with local officials, a senator, and a state representative to discuss issues pertaining to them.

- Youth participated in the annual Melbourne Martin Luther King Parade and spent time with the mayor and local law enforcement.

Standard 1: Management Accountability

1.01 Initial Background Screening (Critical)	Satisfactory Compliance
Background screening is conducted for all Department employees and volunteers and all contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth and confidential youth records. A contract provider may hire an employee to a position which requires background screening before the screening process is completed, but only for training and orientation purposes. However, these employees may not have contact with youth or confidential youth records until the screening is completed, the rating is eligible and the employee demonstrates he or she exhibits no behaviors which warrant the denial or termination of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

The program has a policy and procedures in place regarding the provision of background screenings for all newly hired employees. The program had ten new employees and three new contractors eligible for a background screening during the annual compliance review period. Each employee was found to have a completed and eligible background screening in the Agency for Healthcare Administration (AHCA) Clearinghouse system which was completed prior to each staff's hire date. A review of each of the staff's personnel records found the program reviewed each staff's criminal history report, Staff Verification System (SVS) report, Florida Department of Law Enforcement (FDLE) Automated Training Management System (ATMS), and Central Communications Center (CCC) Person Involvement report prior to hire. Five of the staff were eligible for and had documentation in their records indicating they completed and passed a pre-employment assessment tool. The other staff and contractors were hired into positions which do not require the completion of the pre-employment assessment tool. None of the newly hired staff required an exemption prior to working with youth and did not have a break in service indicated in the SVS. One staff transferred into the program from another program with the same provider and was found to have a new background screening.

A review of the program's volunteer roster and sign-in logs verified the program did not have any volunteers or mentors which required a background screening. The program did not employ interns during the annual compliance review period. The program utilizes teachers which are provider employees. An Affidavit of Compliance with Level 2 Screening Standards was submitted to the Department on January 22, 2020.

1.02 Five-Year Rescreening	Satisfactory Compliance
Background rescreening/resubmission is conducted for all Department employees and volunteers and all contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth and confidential youth records. Employees and volunteers are rescreened every five years from the initial date of employment. When a current provider staff member transitions into the Clearinghouse, the rescreen/resubmission date starts anew and is calculated by the Clearinghouse. (Note: For the new date, see the Retained Prints Expiration Date on the applicant's personal profile page within the Clearinghouse.).	

The program has a policy and procedures in place regarding the provision of a background rescreening every five years of employment for all staff. A review of the employee, volunteer, mentor, and intern roster found the program had four staff applicable for a background rescreening during the annual compliance review period. Each staff was found to have a

completed and eligible background screening in the Agency for Healthcare Administration (AHCA) Clearinghouse system prior to the five-year anniversary date.

1.03 Provision of an Abuse-Free Environment (Critical)	Satisfactory Compliance

The program provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment.

- *The residential program shall post the Florida Abuse Hotline telephone number for youth under the age of eighteen and the Central Communications Center telephone number for youth 18 years of age and older telephone number.*
- *All allegations of child abuse or suspected child abuse shall be immediately reported to the Florida Abuse Hotline.*
- *Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline pursuant to Section 39.201 (1)(a), F.S.*
- *The environment is free of physical, psychological, and emotional abuse (incorporating trauma responsive principles).*
- *A code of conduct for staff who clearly communicates expectations for ethical and professional behavior, including the expectation for staff to interact with youth in a manner promoting their emotional and physical safety, while also incorporating trama responsive practices.*
- *The program shall complete or schedule a TRACE self-assessment.*

The program has a policy and procedures which outline the provision of an abuse-free environment for youth and staff. The policy outlines the requirements of staff to offer youth unhindered and immediate access to the Florida Abuse Hotline by facilitating the youth's request to make a call as soon as possible with no screening. The policy further states staff have the ability and responsibility to call immediately if they suspect abuse. Observations made during the program tour found the program has postings for the Florida Abuse Hotline, as well as contact information for the Central Communications Center (CCC) for youth over the age of eighteen, throughout the program. The executive director was interviewed and reported the shift supervisor will assist youth in calling the Florida Abuse Hotline or will call themselves if warranted by an incident. The supervisor will then notify program administration.

A review of five pre-service and five in-service staff records found each had a signed code of conduct in their personnel records, as well as an acknowledgement of the employee handbook which further outlines the code of conduct for all staff. A review of the employee handbook and an interview with the executive director confirmed the code of conduct includes behaviors prohibited for staff in order to create an abuse-free environment, as well as consequences for the behaviors up to and including termination. The program had four incidents of alleged abuse during the annual compliance review period, two of which were found to be substantiated. All four incidents were reported to the Florida Abuse Hotline and CCC, as required. The program completed a Trauma Responsive and Caring Environment (TRACE) self-assessment and documentation found the program used the results of the assessment to incorporate trauma-responsive principles into the program planning process.

Five youth were interviewed, each reported they felt safe in the program and never had to call the Florida Abuse Hotline. Four youth reported staff are respectful to youth and one reported most staff are respectful; however, some staff make youth feel like their maids. Four youth reported staff never curse around the youth and one youth reported staff do not curse unless the youth are very disrespectful. Five staff were interviewed, each reported they had never observed another staff member prevent a youth from calling the Florida Abuse Hotline or threaten or use profanity toward youth. Four of the staff reported the youth are allowed to make the call, a supervisor is notified, and staff are also allowed to call the Florida Abuse Hotline or CCC. Three staff reported the executive director is notified if an incident occurs and two staff reported the supervisor makes the call to the Florida Abuse Hotline or CCC after an incident. A review of incident reports and youth records found no instances in which the Florida Abuse Hotline should have been called. Observations, documentation, and youth and staff interviews verified the environment is free from physical, psychological, and emotional abuse.

1.04 Management Response to Allegations (Critical)	**Satisfactory Compliance**
Management shall be cognizant of youth and staff needs and provide direction to each on how to access the Florida Abuse Hotline. There is evidence management takes immediate action to address incidents of physical, psychological, and emotional abuse.	

The program had four allegations of abuse during the annual compliance review period, two of which were substantiated and an additional incident which although unsubstantiated, warranted management response. Documentation was found indicating internal investigations were completed for each of the three applicable incidents. For the two incidents which were found to be substantiated for physical abuse, the two staff involved were terminated. For the one incident which was unsubstantiated, the investigation found one staff required follow-up training to address policies not followed during the incident. The documentation supported management took immediate action to address each of the incidents.

The executive director was interviewed and reported staff and youth are trained on their right and ability to call the Florida Abuse Hotline and Central Communications Center (CCC) at the onset of their admission or employment and periodically thereafter. The executive director confirmed two staff were terminated based on the physical abuse perpetrated by them.

1.05 Incident Reporting (CCC) (Critical)	**Satisfactory Compliance**
The program shall notify the Department's Central Communications Center (CCC) within two hours of the incident occurring, or within two hours of any program staff becoming aware of the reportable incident.	

The program had eight incidents which were reported to the Central Communications Center (CCC) during the annual compliance review period, which did not reflect an increase since the last annual compliance review. Five of the CCC incident reports were reviewed and found each incident was reported within the required timeframe. One of the CCC calls was found documented in the program logbook. The program could not locate the program logbooks for July 30, 2019 through December 5, 2019; therefore, the team was not able to validate if the CCC call information was noted in the facilities logbooks.

A review of internal incident reports and grievances found no additional incidents which should have been reported to the CCC. Two incidents which occurred while the annual compliance

review team was on-site were each reported to the CCC within the required timeframe. An interview with the executive director found the staff are to report any incidents to the shift supervisor who is responsible for calling the CCC within the required timeframe and notifying program administration.

1.06 Protective Action Response (PAR) and Physical Intervention Rate	**Satisfactory Compliance**
The program uses physical intervention techniques in accordance with Florida Administrative Code. Any time staff uses a physical intervention technique, such as countermoves, control techniques, takedowns, or application of mechanical restraints (other than for regular transports), a PAR Incident Report is completed and filed in accordance with the Florida Administrative Code.	

The program has a Protective Action Response (PAR) Plan which was submitted to and approved by the Department. The program had three incidents during the annual compliance review period which required a PAR, which is a decrease since the last annual compliance review. The program's PAR rate during the annual compliance review period was 0.84 which is below the statewide Residential PAR rate of 2.41.

Each of the three PAR reports reviewed found the report was completed by the end of the day with statements from all involved staff, a post-PAR interview was completed within thirty minutes with the youth, and was reviewed by a supervisor, PAR trainer, and the executive director or designee within the required timeframes. One of the three incidents required a post-PAR medical review in which the youth reported an injury. The Central Communications Center (CCC) and Florida Abuse Hotline were called, as required. None of the three incidents included the use of mechanical restraints. All of the reports are filed in the PAR binder and maintained in the director of operations' office within forty-eight hours of the incident. The program submitted their monthly summary of PAR incidents to the Department, as required. An interview with the executive director found the program reviews all PAR incidents with the staff on shift during the incident and in management meetings.

1.07 Pre-Service/Certification Requirements (Critical)	**Satisfactory Compliance**
Residential contracted provider staff satisfies pre-service/certification requirements specified by Florida Administrative Code within 180 days of hiring.	

The program has a pre-service training plan which was submitted on February 5, 2019 and approved by the Department's Office of Staff Development and Training on April 1, 2019. The program employs direct care workers to provide supervision to youth and utilizes all other program staff to occasionally supervise youth. All staff employed at the program are found to be trained in Protective Action Response (PAR). Five staff hired during the annual compliance review period were reviewed for pre-service training requirements and each completed over 120 hours of pre-service training. Each of the five staff completed essential skills training in cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), PAR, suicide prevention and intervention, emergency procedures, and child abuse reporting prior to contact with youth and within 180 days of hire. Four of the five staff also completed training in ethics, Prison Rape Elimination Act (PREA), and active shooter training. The one staff who did not complete these trainings transferred from a day treatment program with the same provider and had completed these trainings with their previous program and did not complete them as part of their training for this program. Each of the five staff completed all additional trainings outlined in the program's contract. All pre-service training was documented in the Department's

Learning Management System (SkillPro). Documentation was provided the instructors for the PAR and CPR/first aid/AED trainings were certified to deliver the curriculum.

1.08 In-Service Training	Limited Compliance
Residential contracted provider staff complete twenty-four hours of in-service training, including mandatory topics specified in Florida Administrative Code, each calendar year, effective the year after pre-service/certification training is completed. *Supervisory staff completes eight hours of training (as part of the twenty-four hours of annual in-service training) in the areas specified in Florida Administrative Code.*	

The program has an in-service training plan which was submitted on February 5, 2019 and approved by the Department's Office of Staff Development and Training on April 1, 2019. The program employs direct care workers to provide supervision to youth and utilizes all other program staff to occasionally supervise youth. All staff employed at the program are found to be trained in Protective Action Response (PAR). Five staff were reviewed for in-service training requirements each of which completed between thirty-three and seventy-five hours of in-service training. Each of the five staff was found to have completed training in cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), and Protective Action Response (PAR). Four of the five staff completed at least six hours of training in suicide prevention and one only completed three hours. All training in suicide prevention was instructor-led. Four of the five staff did not complete required in-service training in ethics and three of the staff did not complete training in substance abuse treatment overlay services provided by the program. Two of the staff were supervisors and completed at least eight hours of training in leadership. All training was documented in the Department's Learning Management System (SkillPro). Documentation was provided the instructors for the PAR and CPR/first aid/AED trainings were certified to deliver the curriculum. The program utilizes a training calendar to track required trainings which is updated as changes occur.

1.09 Grievance Process	Satisfactory Compliance
Program staff shall be trained on the program's youth grievance process and procedures. The program adheres to their grievance process and shall ensure it is explained to youth during orientation and grievance forms are available throughout the facility. *Completed grievances shall be maintained by the program for a minimum of twelve months.*	

The program has a policy and procedures in place establishing a grievance process which includes the provision for staff training. The policy outlines three phases of the grievance process, an informal phase where youth are encouraged to speak with staff on shift, a formal phase where the supervisor or director of operations responds to the grievance within seventy-two hours, and an appeal phase where the executive director or designee responds within two days. Grievance forms were found maintained on the program's dormitory common area and accessible to youth. A review of five pre-service and five in-service staff found each received training in the grievance process. The program maintains all grievances in a grievance binder for the past twelve months. The program had seven grievances submitted during the annual compliance review period, five of which were reviewed. Each of the grievances were resolved during the formal phase and were responded to within the required timeframes.

The executive director was interviewed and confirmed the grievance process and phases. Five youth were interviewed, three of the youth reported the forms are placed in the program for youth access and two youth reported there are timelines for the phases of the process. Two of the youth further mentioned the process only takes one day and two other youth reported never having to fill out a grievance form, but staff have told them what to do if they ever wanted to. Each of the five youth reported staff would help them fill out a grievance form. Five staff were interviewed and each of the staff reported the forms are placed on the dormitory and accessible to staff and both the supervisors and the program director review the grievances. Three staff reported the grievance process has associated timeframes and two staff reported youth can request assistance in filling out the forms.

1.10 Interventions and Facilitator Training	Satisfactory Compliance
The program shall implement a delinquency interventions for each youth. Interventions shall include evidence-based practices, promising practices, practices with demonstrated effectiveness, and any other delinquency interventions and treatment services approved by the Department. Staff whose regularly assigned job duties include the implementation of a specific delinquency intervention and/or curriculum must receive training in its effective implementation.	

The program provides delinquency interventions utilizing evidence-based practices, promising practices, or practices with demonstrated effectiveness for each youth. Evidence-based interventions are those designed to reduce the influence of risk factors related to re-offending behavior. The program utilizes The Council for Boys and Young Men (Council) and Impact of Crime (IOC) as the delinquency interventions, with each youth placed in groups according to their identified individual needs. This practice was confirmed by the executive director (ED). Interviews with the program's clinical director and ED confirmed delinquency interventions are delivered by the therapists and designated mental health clinician authority (DMHCA). The ED also advised the youth are matched with their therapists based on a mental health and substance abuse assessment completed within twenty-four hours of admission. There is only one case manager; therefore, all youth are assigned to the same case manager. A review of each of the seven designated staff training records reflected all staff had the appropriate education and qualifications to be hired in their respective positions and completed the required training to facilitate the delinquency intervention groups. The program's daily schedule reflects delinquency intervention and treatment groups are conducted seven days a week, pursuant to the program's contract and a review of sign-in sheets confirmed this practice. Structured, planned programming, and activities are provided for a minimum of sixty percent of the youth's awake hours. A review of five youth individual performance plans supported each youth had at least one delinquency intervention goal addressing an identified priority need. A review of group sign-in sheets validated each youth was participating in an intervention group. An IOC cohort just finished the week prior to the annual compliance review and a Thinking for Change (T4C) cohort would be beginning the next week after the annual compliance review. An IOC group, ART group, and Seven Challenges group were observed during the annual compliance review which validated the groups were delivered, as designed. All five interviewed youth stated they participated in groups including IOC, ART, Seven Challenges, and Boys Council.

1.11 Life and Social Skills Training Provided to Youth	Satisfactory Compliance
The program shall provide instruction focusing on developing life and social skill competencies in youth.	

The program has a policy and procedures which provides interventions and instruction focusing on developing life and social skill competencies to youth through classroom and group instruction and hands-on experiences, as well as role-modeled by staff and program administrators. Youth receive life and social skill intervention services specifically addressing at minimum: communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking to include problem-solving and decision-making. The program provides group Aggression Replacement Training (ART) for life and social skills training. A review of the program's contract indicates the program has staff trained to provide all their required life skills and intervention groups, as well as their mental health and substance abuse groups. A review of group sign-in sheets confirmed the program is providing all contractually required groups to youth according to the activity schedule. A review of five youth case management records showed all youth are participating in life and social skills groups and training, as required. Interviews with the executive director (ED) and clinical director indicated youth attend delinquency and life skills groups daily and are provided an opportunity to practice these skills during their daily routine. Interviews with five youth indicated they are all currently participating in intervention and life and social skills groups to include Impact of Crime (IOC), ART, Seven Challenges, and Council for Boys and Young Men. Youth interviews also indicated the youth learn active listening skills, coping skills, and utilize role playing to model desired skills. Four out of five interviewed youth indicated they have been able to use the skills they have learned in their daily routine. One youth stated they did not feel the skills learned in groups could be utilized outside groups.

1.12 Restorative Justice Awareness for Youth	Satisfactory Compliance
The program shall provide activities or instruction intended to increase youth awareness of, and empathy for, crime victims and survivors, and increase personal accountability for youths' criminal actions and harm to others.	

The program provides the Impact of Crime (IOC) twice a week in the afternoon, in addition to community service projects which helps to increase awareness and empathy for crime victims and survivors. Youth have assisted during library book sales, helped with campus beautification at a local adult education center, and have assisted in creating a therapeutic garden at a local high school for developmentally delayed children. A review of staff training records showed four staff are trained to facilitate IOC. A review of five case management records showed all five youth had completed or are currently participating in an IOC cohort. An informal interview was conducted with the executive director (ED) to determine how youth are exposed to victim's perspective through victim speakers. The ED stated youth have multiple victim perspective speakers throughout their stay at the program, to include monthly speakers, graduation speakers, and mentors. The annual compliance review team was able to observe a restorative justice group and it was determined the group was delivered as designed.

1.13 Gender-Specific Programming	Satisfactory Compliance
A residential commitment program shall provide delinquency interventions and treatment services which are gender-specific and focus on preparing youth to live responsibly in the community upon release from the program.	

The program has a policy and procedures which address gender-specific programming for a male population, pursuant to the contract. The program utilizes Council for Boys and Young Men as the main gender-specific programming and to meet the needs of the program's male population. The group is conducted once a week for an hour and a half. The interviews with the executive director (ED) and clinical director indicated all treatment planning is individualized and focuses on the gender-specific therapeutic needs of each youth, which was also confirmed by review of group sign-in sheets and the five youth interviews conducted during the annual review.

1.14 Internal Alerts System and Alerts (JJIS) (Critical)	Limited Compliance
The program shall maintain and use an internal alert system easily accessible to program staff and keeps them alerted about youth who are security or safety risks, and youth with health-related concerns, including food allergies and special diets. When risk factors or special needs are identified during or subsequent to the classification process, the program immediately enters this information into its internal alert system. The program ensures only appropriate staff may recommend downgrading or discontinuing a youth's alert status. *When risk factors or special needs are identified during or subsequent to the classification process, the program immediately enters this information into the Juvenile Justice Information System (JJIS). Upon recommendation from appropriate staff, JJIS alerts are downgraded or discontinued.*	

The program has a policy and procedures regarding entering alerts into the Department's Juvenile Justice Information System (JJIS) and the use of an internal alert system logbook. During an interview with the program's executive director, it was confirmed the JJIS alert reports and internal alerts are reviewed and signed by staff at the beginning of each shift. The director of case management and the registered nurse update the alerts in JJIS as needed. A review of five youth records found each youth was applicable for having an alert entered into the program's internal alert system and the JJIS alert system. Reviewed documentation supported each youth had the appropriate alert entered into the internal alert system and each was entered into the JJIS alert system. Four out of five youth were removed or downgraded from alert status by appropriate staff in a timely manner. One youth had a medication discontinued six days after date of admission by designated health authority (DHA); however, the medication alert was not closed until almost five months later. Additionally, one youth's alert was entered incorrectly, the youth had a crisis assessment which should have generated a mental health alert; however, a suicide alert was entered instead of the mental health alert. Two out of five youth alerts were found in the logbook. The other three youth's alerts were unable to be found in the logbook due to program misplacing the logbook for four months of the annual compliance review period. One additional youth alert was reviewed to verify alerts in the logbook and the alerts were found in the logbook. The executive director (ED) confirmed only medical staff are allowed to remove or downgrade a medical alert and only mental health staff are allowed to remove or downgrade a mental health alert. All five staff confirmed they are informed of medical and mental health alerts by the internal alert logbook which is reviewed prior to every shift.

1.15 Youth Records (Healthcare and Management)	Satisfactory Compliance
The program maintains an official case record, labeled "Confidential," for each youth, which consists of two separate files: • *An individual healthcare record* • *An individual management record.*	

The program maintains a policy and procedures relating to the maintenance, creation, and storage of individual healthcare, mental health, substance abuse, and case management records for each youth. The program maintains individual, color-coded, hardbound binders for case management, healthcare, and mental health and substance abuse records. Observations of the records found each labeled "confidential" and secured in file cabinets identified as "confidential" in assigned locked offices inaccessible to youth. Observations of the records showed each youth record had the required documentation on the spine and the front of the binder, to include the youth's name, date of birth, county of residence, date of admission, committing offense, and Department identification number (DJJID). Reviewed records showed all the required recent information in chronological order. Documents were organized into required sections and information was separated into designated sections with tabs for legal, demographic, case management with treatment plan and interventions, and correspondence along with a miscellaneous tab.

1.16 Youth Input	Satisfactory Compliance
The program has a formal process to promote constructive input by youth.	

The program has a process to promote constructive input from youth. The program maintains a student council comprised of youth enrolled in the program, giving youth the opportunity to have verbal contact with the program's administration regarding program operational issues, complaints, and/or suggestions. Additionally, the program utilizes grievances, large group meetings, and youth surveys to provide youth input to the program. The student council meets monthly with administration. Student council members are elected by their peers and serve for three months. The program board responds to any grievances by students within five days. Reviewed documentation revealed meetings were held five times during the past six-month period. Student council did not meet in December 2019 and program acknowledged this meeting was missed. Some topics discussed during the youth advisory board meetings included incentive calendar ideas, requests for supplies for recreation, and grievances affecting the majority of the youth population. Five interviewed youth stated they could provide feedback and input if desired. All five interviewed youth reported being able to talk to administration, fill out a grievance, or speak to more senior ranking youth who would then bring concerns to administration. No interviewed youth mentioned the student council as a way to provide youth input. During an informal interview with the executive director (ED), it was revealed the program receives input from the youth regarding programming from the student council, youth surveys, and large group meetings.

1.17 Advisory Board	Satisfactory Compliance
The program has a community support group or advisory board meeting at least every ninety to 120 days. The program director solicits active involvement of interested community partners.	

The program maintains a policy and procedures for maintaining an advisory board. The program maintains a list of community advisory board members from the school board, law enforcement

officials, community partners, faith-based organizations, a local mentoring agency, judiciary, business community, LGBTQI community, victim advocates, and parents/guardians of former/present residents. Reviewed documentation reflected the program's community advisory board met on April 30, 2019, July 23, 2019, October 22, 2019, and January 21, 2020. Attempts were made for recruitment efforts from law enforcement, the judiciary community, other community partners, business community, school board, faith community, victim advocates, and parent/guardians. Parent/guardians are asked if they would like to participate on the advisory board on the exit parent survey all parent/guardians receive once their child completes the program. Reviewed community advisory board agendas and meeting minutes documented the program provides the board members with information regarding program updates, community updates, and giving back to the community. During an informal interview with an advisory board member, it was stated meetings are held quarterly and the program is very receptive to board member's feedback. An interview with executive director revealed the role of advisory board is to provide resources, fundraising, and support to the program. One example of this, was advisory board members helping the program begin their construction vocational program by fundraising for a new building and supplies as well as networking construction professionals who provide their expertise and instruction to the youth.

1.18 Program Planning	Satisfactory Compliance
The program uses data to inform their planning process and to ensure provisions for staffing.	

The program conducts monthly all staff meetings and weekly management meetings to share information with staff and to enhance program planning. A review of the program's meeting binders indicated meetings were held monthly or weekly and were held accordingly during the annual compliance review period. A review of the all staff meeting minutes indicated the program reviews with staff the quality improvement reports, training, red flag issues, medical updates, mental health updates, drill reviews, human resources issues, policy reviews, and safety and security issues. A review of the daily management meetings indicated the management team discussed programming issues, grievances, Central Communications Center (CCC) reports, incident reports, youth issues, education issues, Protective Action Response (PAR) incidents, program trends, alert trackers, sick calls, and staff vacancies. Monthly staff meeting documentation reflected a review of the annual compliance report. The Comprehensive Accountability Report (CAR) is not available until later this year. The program also conducts parent/guardian surveys upon each youth's admission and discharge from the program, and a random sample of half of all youth and parent/guardian surveys on a quarterly basis. The feedback received from the surveys is discussed with administration and used to enhance programming. During an interview with the executive director (ED), it was confirmed the program holds monthly staff meetings and weekly management meetings to keep staff informed of events going on in the program. The ED also established youth and parent/guardian surveys are conducted quarterly and the information collected is shared with staff and used to improve programming.

Five interviewed staff members confirmed the program holds monthly staff meetings. One out of five staff interviewed also stated meetings were held bi-weekly. The five interviewed staff indicated CCC calls, Protective Action Response (PAR), maintenance issues, safety concerns, youth behavior, staff incentives, youth supervision, alerts, and program planning are discussed during monthly staff meetings. Three out of five staff indicated they are briefed on annual reports. Two out of five staff stated they were not briefed on survey results. All five interviewed staff indicated communication at the program is very good, good, or fair. All staff indicated the

administration has an open-door policy and they can communicate any concerns with the administration.

1.19 Staff Performance	**Satisfactory Compliance**
The program ensures a system for evaluating staff, at least annually, based on established performance standards.	

The program has a policy and procedures addressing the evaluation of staff performance. Performance evaluations are completed within forty-five days of hire, after ninety days of hire, and then annually thereafter, for all staff by department heads. During an interview with the executive director (ED), it was found annual evaluations are completed to provide feedback to staff regarding their performance over the prior year on their overall specific job duties. Goals are also identified for the upcoming year. Performance evaluations address performance standards to include job duties, job knowledge and competency, teamwork, and professionalism. Evaluations are explicit to different categories of staff positions. Staff are rated on a one to four scale with four being the highest. Each performance evaluation provides an overall numerical rating at the end of the evaluation.

Five staff were interviewed about performance evaluations. Three staff indicated they receive annual performance evaluations, one staff indicated performance evaluations are completed once every six years, and one staff stated they had only been working at the program two months and did not know when performance evaluations are completed. Five personnel records were reviewed in which two were supervisory records. Each included the specific job description and applicable performance evaluation. All key positions were filled at the time of the annual compliance review.

1.20 Recreation and Leisure Activities	**Satisfactory Compliance**
The program shall provide a variety of recreation and leisure activities.	

The program's activity schedule was reviewed along with the program's policy and procedures regarding recreation and leisure activities. The program has a range of supervised and structured indoor and outdoor recreation activities available to youth. Activities include basketball, football, outside workouts, volleyball, playing cards, chess, dominos, reading, and boardgames. The recreation therapist has a Bachelor of Science degree in physical science, which is in accordance with the contract. The therapeutic activity specialist has a bachelor's degree in physical education with experience working as a physical education teacher and working in juvenile corrections. Five interviewed youth indicated they are provided a variety of activities with varying degrees of mental and physical exertion throughout the day. Five interviewed youth and five interviewed staff indicated youth are provided with at least one hour of large muscle activity each day. Recreation activities promote community wellness which allows youth to contribute to the group culture, promotes social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. A review of the logbook reflected a minimum of an hour of recreation activity is provided daily for all youth. The program contract does not require wellness goals to be incorporated into youth's treatment plans. Youth are provided an opportunity to provide input into the rules and operation of the program through the student council, large group meetings, and youth survey.

Standard 2: Assessment and Performance Plan

2.01 Initial Contacts to Parent/Guardian and Court Notification	Satisfactory Compliance
The program notifies the youth's parent/guardian by telephone within twenty-four hours of the youth's admission, by written notification within forty-eight hours of admission, and notify the youth's committing court, assigned juvenile probation officer (JPO) and post residential services counselor (if applicable) in writing within five working days of any admission.	

The program has a policy and procedures ensuring each youth's parent/guardian and court is notified of their admission. Each of the five youth records reviewed, had documentation indicating the parent/guardian was notified by the program within twenty four hours of admission by telephone. The program notified the parent/guardian in writing within forty-eight hours of admission for each youth. The committing court was notified for each youth, in writing, within five working days of each youth admission.

2.02 Youth Orientation	Satisfactory Compliance
The program shall provide each youth an orientation to the program rules, expectations, goals of the program, and services applicable to youth, to begin within the day of, or prior to, the youth's admission.	

The program has a policy and procedures ensuring each youth admitted to the program is provided an orientation on the day of admission. Each of the five youth records reviewed had documentation indicating the youth received orientation on the day of the admission. The orientation process included each of the required elements. The youth signed acknowledging receiving orientation, which also included receiving a copy of the behavior management and youth handbook. During the annual compliance review, the program did not have any admissions; therefore, observations of an admission could not be conducted. Each of the interviewed youth confirmed their orientation started on their admission date and included rules, expectations and introduction to staff.

2.03 Written Consent of Youth Eighteen Years or Older	Satisfactory Compliance
The program obtains written consent of any youth eighteen years of age or older, unless the youth is incapacitated and has a court-appointed guardian, before providing or discussing with the parent/guardian any information related to the youth's physical or mental health screening, assessment, or treatment.	

The program has a policy and procedures ensuring youth eighteen years or older provide consent prior to release of information. One of the five youth selected for the review were applicable; therefore; the program provided two additional applicable youth records for review. Each of the three records included signed written consents.

2.04 Classification Factors, Procedures, and Reassessment for Activities	Satisfactory Compliance
The program utilizes a classification system, in accordance with Florida Administrative Code, promoting safety and security, as well as effective delivery of treatment services. Initial classification should be used for the purposes of assigning each newly admitted youth to a living unit, sleeping room, and youth group or staff advisor. *Youth are reassessed and reclassified, if warranted, prior to considering an increase in privileges or freedom of movement, participation in work projects, or other activities involving tools or instruments which may be used as potential weapons or means of escape, or participation in any off-campus activity.*	

The program has a policy and procedures ensuring the program conducts the classification process for each youth admitted to the program. The program conducts a classification meeting to review each youth information/documentation. Documents include initial interviews, records, observations, and screening findings. The program had documentation showing the alerts were updated continually. The executive director reported the classification system is used which includes factors such as physical status, age/maturity, gang affiliation, medical needs, and sexual aggressiveness at a minimum. For example, youth are assigned to a dorm which consist of youth with similar age/maturity.

Each of the five reviewed youth records included an initial classification form which included each of the required elements. In addition, each of the youth had a Victimization and Sexual Aggressive Behavior (VSAB) entered in the Department's Juvenile Justice Information System (JJIS) upon admission. The program completed reassessments monthly for each youth due to increase of privileges/freedom of movement, participation in work projects or off-campus activities.

2.05 Gang Identification: Notification of Law Enforcement	Satisfactory Compliance
The program shall gather information on gangs, (e.g., gang members, tattoos, other body markings) and share this information with law enforcement.	

The program has a policy and procedures ensuring notification of law enforcement of gang activities. Two of the five youth selected were applicable for gang association; therefore, the program provided one additional record for review. Each of the three records included documentation indicating the local law enforcement was notified by the program of identification of the youth's gang involvement. The program also notified the youth's home county law enforcement agency of placement in the program. The program entered the gang alert in the Department's Juvenile Justice Information System (JJIS) upon identification. The program notified the educational provider serving the program and youth's juvenile probation officer (JPO); the post residential counselor was not applicable.

2.06 Gang Identification: Prevention and Intervention Activities	Limited Compliance
A residential commitment program shall implement gang prevention and intervention strategies. The residential commitment program shall provide intervention strategies when youth are identified as being a criminal street gang member, are affiliated with any criminal street gang, or are affiliated with any criminal street gang, or are at high risk of gang involvement.	

The program has a policy and procedures ensuring gang identified youth are provided prevention and intervention activities. The program provides Impact of Crime (IOC) as their gang intervention/prevention curriculum. There is documentation on each of the youth performance plans with gang related goals/interventions. In addition, a review of sign-in sheets revealed each youth attended and participated in IOC while in the program.

2.07 Residential Assessment for Youth (RAY) Assessments and Re-Assessments	Satisfactory Compliance
The program shall ensure an initial assessment of each youth is conducted within thirty days of admission. The program shall maintain all documentation of the initial assessment process in JJIS. The program shall ensure a reassessment of each youth is conducted within ninety days. The program shall ensure any other updates or reassessments are completed when deemed necessary by the intervention and treatment team to effectively manage the youth's case. The program shall maintain all reassessment documentation in the youth's official youth case record.	

The program has a policy and procedures ensuring youth in the program have completed initial Residential Assessment for Youth (RAY) and reassessments. Each of the five reviewed youth records contained a completed initial RAY within thirty days of their admission and the RAY was entered in the Department's Juvenile Justice Information System (JJIS). Two of the five were applicable for a RAY reassessment, which was completed within ninety days of the initial RAY assessment. The program maintained each of the assessments and reassessments in each of the youth records.

2.08 Youth Needs Assessment Summary (YNAS)	Satisfactory Compliance
The program shall ensure a Youth Needs Assessment Summary (YNAS) of each youth is conducted within thirty days of admission. The program shall maintain all documentation of the initial assessment process in JJIS on the YNAS.	

The program has a policy and procedures ensuring the program completes the Youth Needs Assessment Summary (YNAS) for each youth entering the program. Each of the five youth had a YNAS within thirty days of their admission. Each YNAS was entered into the Department's Juvenile Justice Information System (JJIS).

2.09 Performance Plan Development, Goals and Transmittal (Critical)	Satisfactory Compliance
The intervention and treatment team, including the youth, shall meet and develop the performance plan, based on the findings of the initial assessment of the youth, within thirty days of admission. *For each goal, the performance plan shall specify its target date for completion, the youth's responsibilities to accomplish the goal, and the program's responsibilities to enable the youth to complete the goal.* *Within ten working days of completion of the performance plan, the program shall send a transmittal letter and a copy of the plan to the committing court, the youth's juvenile probation officer (JPO), the parent/guardian, and the Department of Children and Families (DCF) counselor, if applicable.*	

The program has a policy and procedures in regard to the development of performance plans and transmittals. The individualized performance plan for each youth was completed within thirty days of the youth's admission, after the initial assessment. During the development of the performance plan, the treatment team leader, youth, administrative representative, treatment staff, education, and the Department of Children Families case worker, when applicable, were present. The program mailed a copy of the performance plan for review and signature to the parent/guardian or Department of Children and Families; however, none were returned to the program. The remaining treatment team members signed and dated the performance plans. A copy of the performance plans was mailed to the committing court, juvenile probation officer, parent/guardian, and the Department of Children and Families case worker, when applicable. Each of the five reviewed performance plans included the three top criminogenic needs, delinquency interventions, individualized goals, transition activities, youth and parent/guardian responsibilities and target dates for goals. Each of the five youth interviewed were able to explain their treatment and performance goals, and what is expected during treatment team meetings. Three of the five interviewed youth reported receiving a copy of their performance plan, two reported not receiving a copy; however, knew they could request a copy at any time.

2.10 Performance Plan Revisions	Satisfactory Compliance
Performance reviews shall result in revisions to the youth's performance plan when determined necessary by the intervention and treatment team.	

The program has a policy and procedures in regard to the process of revising performance plans. Three of the five youth reviewed had a revised performance plan as a result of the Residential Assessment for Youth (RAY) reassessment, progress toward completing a goal and new information revealed. The remaining two did not require a revised performance plan at the time of the annual compliance review.

2.11 Performance Summaries and Transmittals	Satisfactory Compliance
The intervention and treatment team shall prepare a Performance Summary at ninety-day intervals, beginning ninety days from the signing of the youth's performance plan, or at shorter intervals when requested by the committing court. *Additionally, the intervention and treatment team shall prepare a performance summary prior to the youth's release, discharge, or transfer from the program.* *The program shall distribute the Performance Summary, as required, within ten working days of its signing.*	

The program has a policy and procedures regarding performance summaries. Three of the five reviewed youth records were applicable for performance summaries. The remaining two youth had not been in the program long enough to receive a performance summary. Each of the three applicable records included a performance summary which was completed ninety days after the signing of the performance plan. None of the applicable records included a release, discharge, or transfer summary. The summaries included youth status on each performance plan goal, overall treatment progress, academic status, behavior, level of motivation/readiness to change, interaction with peers/staff, overall behavior adjustment to the program, and positive and negative events. The original performance summaries were located in each record. None of the three youth were allowed to read and add comments prior to signing; this section on the summary was blank. Each of the three applicable youth received a copy of their summary. The treatment team leader, staff member preparing summary, executive director or designee, and youth signed and dated the summaries. The summaries were mailed to the committing court, juvenile probation officer, parent/guardian, and the Department of Children and Families caseworker, when applicable. One of the five interviewed youth reported receiving a copy of their performance summary; the remaining youth were not applicable for a summary.

Three closed youth records were reviewed for release summaries. Each of the three records included the original signed release summary and Pre-Release Notification (PRN). The summary and PRN were submitted at least forty-five days prior to the youth's release date. The committing court did not object to the release in each case. There was documentation in each of the three records the program mailed a letter to the parent/guardian notifying of the approved release. In two of the three records, upon approval, the program completed the exit Residential Assessment for Youth (RAY). The remaining record contained an exit RAY which was completed ten days after release. None of the youth were applicable for sexually violent predator program (SVPP) and victim notification.

2.12 Parent/Guardian Involvement in Case Management Services	Satisfactory Compliance
The program shall, to the extent possible and reasonable, encourage and facilitate involvement of the youth's parent/guardian in the case management process.	

The program has a policy and procedures ensuring parent/guardians are involved in case management services. In each of the five records reviewed, there was evidence the program encouraged parent/guardians through different methods. The records included documentation letters were mailed to the parent/guardian in regard to providing input in the assessment phase, development of plans, and treatment team meetings. The program also communicates through telephone contact to invite and remind parents/guardians about pending meetings in regard to

their child. If a parent/guardian is not able to participate in scheduled meeting, they are provided the opportunity to provide written/verbal input prior to the meeting.

During the annual compliance review, three treatment team meetings were observed. The parent/guardian and juvenile probation officer participated by telephone in order to provide input in each youth's treatment while in the program. Each of the five interviewed youth reported their parents/guardians were involved in their treatment while in the program. The executive director reported parental involvement is encouraged and available by phone contact, Skype/video conferencing, family visits, communication by mail, and assistance by JPO involvement if necessary; also, by covering fuel cost for those parents/guardians in need of assistance.

2.13 Members of Treatment Team	Satisfactory Compliance
The team includes, at a minimum, the youth, representatives from the program's administration and residential living unit, education, and others responsible for providing or overseeing the provision of intervention and treatment services.	

The program has a policy and procedures identifying members of the treatment team. Treatment team consists of the youth, parent/guardian, juvenile probation officer (JPO), administration, and others directly responsible for providing services (i.e., case manager, recreation therapist, Department of Children and Families, education and therapist). The program had the director of operations (DO) participate as the living unit representative; however, the DO is a member of administration and not a part of the living unit. It should also be noted during treatment team meetings, the DO had no administrative duties. Treatment team signatures support the executive director participated in treatment teams serving the administrative role. The program invites each youth JPO, parent/guardian, and other pertinent parties. Each party is invited through email, letter, and telephone correspondence.

2.14 Incorporation of Other Plans Into Performance Plans	Satisfactory Compliance
The youth's performance plan shall reference or incorporate the youth's treatment or care plan.	

The program has a policy and procedures in regard to performance plans incorporating other treatment plans. A review of five performance plans revealed each plan included the youth's academic plan, safety plan, delinquency interventions, and treatment plans (mental health/substance abuse). One of the five youth is in the custody of the Department of Children and Families (DCF) and the performance plan included the care plan.

2.15 Treatment Team Meetings (Formal and Informal Reviews)	Satisfactory Compliance
A residential commitment program shall ensure the intervention and treatment team meets every thirty days to review each youth's performance, to include RAY reassessment results, progress on individualized performance plan goals, positive and negative behavior, including behavior resulting in physical interventions. If the youth has a treatment plan, review their treatment plan progress.	

The program has a policy and procedures ensuring youth participate in both formal and informal treatment team meetings. Informal treatment team meetings are to be held bi-weekly and formal treatment team meetings are held at least every thirty days. A review of five youth records revealed formal and informal treatment team meetings were held as required. The formal and informal reviews documented the youth's name, date of review, comments from attendees, brief

synopsis of progress, performance plan revisions, progress on performance plan goals, positive/negative behaviors, behaviors resulting in physical interventions, treatment progress, Residential Assessment for Youth (RAY) reassessment results, and youth providing skills acquired in the program.

During the annual compliance review, three formal treatment team meetings were observed. During the meetings, the executive director, director of operations, medical, education, mental health, and case management staff were present. The parent/guardian and juvenile probation officer participated by telephone. The team discussed each youth's overall progress in the program to include behaviors, participation in treatment groups, and the team encouraged the youth to continue to work on goals. Each of the five interviewed youth reported being able to demonstrate skills learned while in the program and staff review their goals and progress with them.

2.16 Career Education	Satisfactory Compliance
Staff shall develop and implement a vocational competency development program.	

The program offers type 2 Career Education programming. The elements of this course content include students investigating individual career choices based upon their personal abilities and interests through the utilizing of My Career Shines. During participation in this course, youth learn to create resumes and complete job applications. The executive director reported, Culinary (food handler certifications-SafeStaff and ServSafe), Construction, and Certified Personal Trainers are provided to youth while in the program. The lead teacher reported the youth are able to receive vocational training and General Equivalency Diplomas (GED).

The course work also includes students having the opportunity to earn various employment certificates in ServeSafe (food handling) which is supported by the National Restaurant Association. Other offerings include cardiopulmonary resuscitation (CPR) and becoming a certified medical administrative assistant (CMAA). Three closed records were examined and all three provided evidence of the youth participating in career choice making activities, the creation of resumes, the completion of job applications, the archiving of earned certifications and a scheduled post treatment appointment with their local Career Source Center.

2.17 Educational Access	Satisfactory Compliance
The facility shall integrate educational instruction (career and technical education, as well as academic instruction) into their daily schedule in such a way ensuring the integrity of required instructional time.	

The program operates on a year-round basis providing educational and career-related programs for 250 days of instruction distributed over twelve months; which includes a minimum of twenty-five hours of instruction weekly. Although the program uses ten days or less for teacher planning and training, the youth participate in the educational component receive academic credit for the educational experiences. As it pertains to following a strict schedule of classes with minimal interferences, a review of the logbook determined classes occur on time and barring medical emergencies or other critical interruptions, the classes meet regularly. This was verified by evidence derived from the program's logbooks, from the interviews of the youth in the program, as well as an interview conducted with the executive director and the program's lead educator. None of the five interviewed youth reported experiencing interruptions during school.

2.18 Education Transition Plan	Satisfactory Compliance
Upon admission, staff and youth develop an education transition plan which includes provisions for continuation of education and/or employment.	

The program has a policy and procedures addressing transition, release, and discharge. Three closed youth records were reviewed and each confirmed each youth had an individual education transition plan which were based upon the youth's post-release goals. Each plan addressed services and interventions founded upon the youth's assessed educational needs and post-release goals. Each transition plan was recognized and accepted with signature by the youth, the youth's parent/guardian, a representative of the program's education, the youth's juvenile probation officer, the program's transitional representative, certified school counselor, registrar of the program's district, and others involved post-release, if applicable.

The plan incorporates specific monitoring responsibilities by explicitly identified individuals who are responsible for the reintegration and coordination for the provision of support services. As part of preparing the youth for transition from the program, the education program involves the youth formulating with employment as a transition goal with appropriate coaching in: choosing of a career choice, creating and writing of resumes, completion of employment applications, as well as conducting mock job interviews. Each of the three youth records indicated the required transition activities, target dates, and individual responsibilities were identified.

2.19 Transition Planning, Conference, and Community Re-entry Team Meeting (CRT)	Satisfactory Compliance
A residential commitment program shall ensure the intervention and treatment team is planning for the youth's successful transition to the community upon release from the program, when developing each youth's performance plan and throughout its implementation during the youth's stay. *During the transition conference, participants shall review transition activities on the youth's performance plan, revise them if necessary, and identify additional activities/services as needed. Target completion dates and persons responsible for their completion shall be identified during the conference. The intervention and treatment team leader shall obtain conference attendees' dated signatures, representing their acknowledgement of the transition activities and accountability for their completion pursuant to the youth's performance plan.* *Each youth must attend their scheduled Community Re-entry Team (CRT) meeting prior to discharge.*	

The program has a policy and procedures ensuring youth pending discharge have a transition/exit conference and Community Re-entry Team (CRT) meeting. In each of the three closed records reviewed, there was documentation a transition conference was held at least sixty days prior to pending release date. The program invited the juvenile probation officer, parent/guardian, education and other treatment members to participate either by providing written or verbal input. None of the youth are under Department of Children and Families custody. The transition conference was attended by the youth, treatment team leader, executive director, and other members as evident of signatures on each form. During the transition meeting, the youth's transition activities and revised performance plan goals were discussed. The transition activities included target dates and persons responsible for completion. For those who could not attend, the program mailed the transition conference form to review and sign.

In each of the three closed records the CRT meeting was held prior to the youth's release. There was documentation in each of the records the youth and case manager participated in the meeting by telephone. The outlook invite was located in each of the three records.

2.20 Exit Portfolio	Satisfactory Compliance
The residential commitment program will assemble an exit portfolio for each youth to assist the youth once he/she is released back into the community.	

The program has a policy and procedures ensuring youth pending release develop an exit portfolio. Three closed records were reviewed for exit portfolio and each youth were over fifteen years of age. During the transition conference, the exit portfolio was initiated. One of three youth had a state-issued identification card and birth certificate. The remaining two records had documentation indicating the program attempted to obtain both a state-issued identification card and birth certificate; however, the parents/guardians did not provide necessary information. Each of the three closed records included a copy of the transition plan, calendar with all upcoming appointments, education documents, resume, and a sample employment application. The program attempted to assist each youth with obtaining Social Security card, but the parent/guardian did not provide necessary documents.

The exit portfolio was verified during the exit conference. The three reviewed youth received the exit portfolio at the time of release. In each of the three closed records, there was documentation the program forwarded the exit portfolio to the juvenile probation officer (JPO).

2.21 Exit Conference	Satisfactory Compliance
An exit conference shall be conducted, in addition to a formal or informal meeting, to review the status of goals developed at the transition conference and finalize release plans.	

The program has policy and procedures in regard to an exit conference being held for youth being released from the program. Three closed records were reviewed for exit conferences. Each of the three exit conferences were held separate from the transition and Community Re-Entry Team (CRT) meetings. The treatment team leader, parent/guardian, education, juvenile probation officer (JPO), youth, and other team members attended the exit conference for each youth. During the exit conference, the team reviewed the youth's status of transition activities and finalized plans for release.

Each record had documentation the exit conference was conducted after the program notified JPO of release. In each record, the exit conference was held at least fourteen days prior to the youth's release. The exit conference form was located in each record. It was confirmed the date of admission and date of discharge matched the date in the juvenile justice information system (JJIS).

Standard 3: Mental Health and Substance Abuse Services

3.01 Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory Compliance
Each program director is responsible for the administrative oversight and management of mental health and substance abuse services in the program. *Programs with an operating capacity of 100 or more youth, or those providing specialized treatment services, must have a single licensed mental health professional designated as the Designated Mental Health Clinician Authority (DMHCA) who is responsible for the coordination and implementation of mental health and substance abuse services in the facility/program.* *Programs with an operating capacity of fewer than 100 youth or those not providing specialized treatment services, may have either a DMHCA or a Clinical Coordinator.*	

The program contracts with the provider Circles of Care (COC) who provides all mental health and substance abuse services at the program. COC provides the program with a designated mental health clinician authority (DMHCA), who is a licensed mental health clinician (LMHC). A review of the Department of Health Medical Quality Assurance license search website revealed the DMHCA's license is clear and active in the State of Florida expiring on March 31, 2021. COC also provides another licensed professional who provides back-up services in the absence of the DMHCA. A review of the Department of Health Medical Quality Assurance license search website revealed the back-up licensed professional has a clear and active in the State of Florida expiring on March 31, 2021.

An interview with the DMHCA indicated they are on-site weekly and work Monday through Friday. A review of sign-in sheets for the DMHCA confirmed they were on-site weekly as required by the contract between COC and the program. The DMHCA also indicated they work weekends and are on-call twenty-four hours a day, seven days a week. During the interview, the DMHCA indicated their role at the program is to provide oversight and supervision of all mental health and substance abuse services and to oversee the clinical staff. The DMHCA further indicated they ensure fidelity checks are completed for group services, review, and approve documentation conducted by non-licensed staff. The DMHCA also indicated they conduct all program suicide assessments and crisis assessments. The DMHCA also provides weekly, on-site supervision to the non-licensed staff at the program. During the weekly supervision, the DMHCA reviews other clinical documentation such as treatment plan reviews, assessments of suicide risk, and weekly progress notes with non-licensed clinicians. A review of the DMHCA's position description confirmed they are responsible for oversight of the program's mental health and substance abuse services. The job description further confirmed the DMHCA's responsibilities from the DMHCA's interview.

3.02 Licensed Mental Health and Substance Abuse Clinical Staff (Critical)	Satisfactory Compliance
The program director is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors shall ensure clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience.	

The program utilizes the services of three licensed clinicians. The program's designated mental health clinician authority (DMHCA) is a licensed mental health counselor (LMHC) with a current and active license in the State of Florida expiring on March 31, 2021 The program's second

licensed clinician is a licensed mental health counselor (LMHC), who serves as the program's back-up to the DMHCA, with a current and active license in the State of Florida expiring on March 31, 2022. The third licensed professional is a licensed clinical social worker (LCSW), who provides services to the youth at the program on a part-time basis; their license is current and active in the State of Florida expiring on March 31, 2021.

3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff	Limited Compliance
The program director is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors shall ensure clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience.	

The programs contract with Circle of Care (COC) requires the program to have two master's-level clinicians and one and a half part-time clinicians. A review of the providers staff roster indicated the program has one master's-level clinician and three bachelor's-level clinicians. COC was able to provide documentation to support the program is currently advertising for the second master's-level clinician. The program is licensed under Chapter 397, F.S. to provide outpatient services. The license expires on June 27, 2020.

During the six-month review period, the program had a total of four non-licensed staff working at the program. A review of the four clinician's staff records revealed one had a master's-level degree and three had a bachelor's-level degree from an accredited university or college in an appropriate field of study. The provider COC does not allow non-licensed clinicians to complete suicide or crisis assessments. During the review, it was confirmed none of the four non-licensed clinicians' complete Assessments of Suicide Risk or follow-up Assessments of Suicide Risk; therefore, they do not require training and supervision in assessing suicide risk, mental health crisis intervention, and emergency mental health services.

All non-licensed clinicians work under the direct supervision of the DMHCA. The non-licensed clinicians provided both mental health and substance abuse services to the youth at the program. The DMHCA provided weekly direct supervision to all non-licensed clinicians. An interview with the DMHCA indicated direct supervision normally occurs on Friday for one hour. A review of the program's direct supervision binder revealed direct supervision was completed weekly by the DMHCA; however, two clinicians did not receive supervision the same week they provided services to the youth on six different weeks for the period of October 28, 2019 thru February 2, 2020. During the debriefing process, the program advised the two clinicians reviewed the missing weekly supervision documentation with the DMHCA the week they returned to the facility. A review of the clinical supervision logs did confirm the two clinicians did review the weekly supervision they missed upon their return to work.

3.04 Mental Health and Substance Abuse Admission Screening	Satisfactory Compliance
The mental health and substance abuse needs of youth are identified through a comprehensive screening process ensuring referrals are made when youth have identified mental health and/or substance abuse needs or are identified as a possible suicide risk.	

The program has a policy and procedures in place outlining the program's process for mental health and substance abuse admission screenings for all youth who enter the program. The

policy indicates each youth is to receive a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) and an Assessment of Suicide Risk (ASR) upon admission.

A review of five youth mental health and substance abuse records revealed upon each youth's admission, the clinical team completed a MAYSI-2 and ASR. All MAYSI-2s and ASRs were completed in the Department's Juvenile Justice Information System (JJIS) database. All MAYSI-2s were completed by either the director of case management or the program's case manager, who both have been trained to complete the assessment. There was also documentation in each youth's record to indicate the clinician completed a review of all available information to include the youth's commitment packet, reports, and records for existing documentation of mental health and substance abuse problems.

Three of the five youth's MASYI-2s indicated further assessment was required and a referral was made for further evaluation. Two youth's MASYI-2s indicated the staff believed the youth had mental health or substance abuse problems and required further assessment based on observations and information reviewed. All five records also contained a completed ASR and all ASRs recommended the youth be continued on standard supervision, as the youth were not at risk for suicide. All five youth were also referred for a comprehensive assessment due to either prior suicide ideations and/or substance abuse issues. During an interview with the executive director (ED) indicated upon each youth's admission, the youth are assessed by the clinical team utilizing the MAYSI-2.

3.05 Mental Health and Substance Abuse Assessment/Evaluation	Satisfactory Compliance
Youth identified by screening, staff observation, or behavior after admission as in need of further evaluation must be referred for a Comprehensive Mental Health Evaluation and/or Comprehensive Substance Abuse Evaluation or Updated Evaluation.	

The program has a policy and procedures in place indicating all youth who enter the program shall receive a new mental health and substance abuse assessment within thirty days of admission. The program is licensed through the Department of Children and Families (DCF) in accordance with Chapter 397, Florida Statutes, to provide outpatient substance abuse treatment to the youth in the program. The license expires on June 27, 2020.

A review of five youth mental health and substance abuse records revealed each youth had a new mental health and substance abuse evaluation completed within thirty days of admission. Three of the evaluations were completed by a licensed mental health clinician. The remaining two evaluations were completed by a non-licensed clinician and were approved by a licensed professional within ten calendar days of completion. All five reviewed evaluations contained each youth's demographic information, reason for the evaluation, relevant background information, behavioral observations, mental status examinations, interview or procedures administered, discussion of findings, diagnostic impression, Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnosis, recommendations, patterns of alcohol and drug abuse, impact of alcohol and drugs on major life areas, risk factors of continued alcohol and drug use, and clinical impressions. All reviewed records contained a signed consent for substance abuse services and release of substance abuse information.

3.06 Mental Health and Substance Abuse Treatment	Satisfactory Compliance
Mental health and substance abuse treatment planning in Departmental facilities focuses on providing mental health and/or substance abuse interventions and treatment to reduce or alleviate the youth's symptoms of mental disorder and/or substance abuse impairment and enable youth to function adequately in the juvenile justice setting. *The treatment team is responsible for assisting in developing, reviewing, and updating the youth's individualized and initial mental health/substance abuse treatment plans.*	

The program has a policy and procedures in place outlining the program's mental health and substance abuse services. A review of five youth mental health and substance abuse records revealed all youth were assigned to a multidisciplinary treatment team on the day of admission. The program combines each youth's mental health and substance abuse treatment team meetings with each youth's case management treatment team meeting. All treatment teams consist of all required parties outlined in Florida Administrative Code. During the annual compliance review, observation of three youth's multi-disciplinary treatment team meetings confirmed all required members of the treatment team were present at all attended meetings. Discussed at the meeting was the youths' treatment goals, behavioral issues, and the youths' progress. Each member of the treatment team was provided an opportunity to discuss the youth's progress and the youth was also given an opportunity to talk with the team and demonstrate skills they learned while in the program.

A review of the five records confirmed each youth had a signed consent to receive substance abuse services and release substance abuse information. Three of the five reviewed records had a properly executed Authority for Evaluations and Treatment (AET). One of the remaining youth was eighteen years of age and signed an authorization for use or release information form indicating the individuals who were able to receive information about their mental health, substance abuse, case management, and educational services. The other youth was under the care of the Department of Children and Families (DCF) and had a signed court order for the youth to receive treatment services while at the program. All reviewed records confirmed each youth was receiving mental health and substance abuse services from the program staff. A review of the five youth's individual progress notes and group sign-in sheets reflected mental health groups had no more than ten youth in a group and substance abuse groups did not have more than fifteen youth in a group. Observations of mental health and substance abuse groups also confirmed the groups had the appropriate amount of youth participating. A review of each facilitator's training record reflected they received proper training in mental health and substance abuse services, as well as training to facilitate each curriculum they taught. All five youth records contained documentation each youth participated in daily groups for substance abuse or mental health issues, monthly individualized sessions, monthly family sessions, and supportive sessions, when necessary. All services provided to the youth were documented on a treatment note which contained all required elements of the mental health and substance abuse form Counseling/Therapy Progress Notes, except for the youth's date of birth.

During an interview with the designated mental health clinician authority (DMHCA) indicated the program provides mental health and substance abuse treatment services through the provision of substance abuse overlay services. The DMHCA indicated the program conducts group treatment daily and all youth receive substance abuse services the entire time they are at the program. The DMHCA also indicated each youth receives monthly family and individual sessions or more as deemed necessary by the clinician. The DMHCA indicated if a youth does not attend group or refuses to attend group, the youth will receive supportive services from a

clinician. The DMHCA indicated a lot of the time, groups are conducted outside in the program's gazebo or on the recreation field which increases youth participation in the group.

Five interviewed staff indicated they did not facilitate group treatment and one staff expanded their answer to include the fact the provider Circle or Care provides all treatment services. Five youth were interviewed on group participation and each stated they were participating in groups and were receiving specialized therapies. All interviewed youth expanded on their responses and indicated they were participating in family therapy and individual counseling.

3.07 Treatment and Discharge Planning (Critical)	Satisfactory Compliance
Youth determined to have a serious mental disorder or substance abuse impairment, and are receiving mental health or substance abuse treatment in a program, shall have an initial or individualized mental health or substance abuse treatment plan. When mental health or substance abuse treatment is initiated, an initial or individualized mental health or substance abuse treatment plan is completed. *All youth who receive mental health and/or substance abuse treatment while in a residential program shall have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services upon youth's release from the facility.*	

The program has a policy and procedures in place outlining the program's treatment services and discharge planning. A review of five youth mental health and substance abuse (MHSA) records revealed each youth had an initial MHSA treatment plan completed the day of their admission. All initial MHSA treatment plans were developed on a program form which contained all elements of the Department's MHSA form, entitled Initial Mental Health/Substance Abuse Treatment Plan. The form was missing each youth's home circuit. All five initial treatment plans were completed within seven days of the onset of treatment or due to the youth being prescribed psychotropic medications. Three of the initial plans were completed by a licensed professional and two were completed by a non-licensed clinician. The two plans completed by non-licensed staff were reviewed and signed by a licensed professional within ten days of completion. All plans were signed by all treatment team members who participated in the development of the plan. Three of the plans identified the youth's psychiatric needs and included medication and frequency of monitoring by the psychiatrist.

Each of the records contained an individualized treatment plan completed within thirty days of admission. All individualized treatment plans were developed on a program form which included all elements of the Department's form entitled, Individualized Mental Health/Substance Abuse Treatment Plan. Two of the reviewed plans were completed by a licensed professional and the remaining three plans were completed by a non-licensed clinician which were reviewed and signed by a licensed professional within ten days of completion. All individualized treatment plans were developed with input from all required treatment team members and the plans were signed by all treatment team members. Three of the five individualized treatment plans were applicable for psychiatric services and medication monitoring and the information was found in all applicable plans. All five individualized treatment plans documented the prescribed services outlined for each youth's individualized treatment such as group treatment, individual sessions, family sessions, and psychiatric services. Four of the five reviewed records required an individualized treatment plan review which were completed on a program form with all elements of the Department's MHSA form entitled, Individualized Mental Health/Substance Abuse Treatment Plan Review. The fifth record was not applicable because the youth had not been in

the program long enough to have a treatment plan review. The four applicable records contained treatment plan reviews completed every thirty days for a total of thirteen individualized treatment plan reviews. All individualized treatment plan reviews contained documentation all required treatment team members participated in each treatment team review meeting.

Three closed youth records were reviewed to verify the program's mental health and substance abuse discharge process. All three records contained a completed mental health substance abuse discharge summary entitled Mental Health/Substance Abuse Treatment Discharge Summary. None of the three closed records revealed the youth was at risk of suicide when being discharged from the program. All three MHSA discharge plans contained information needed for each youth to maintain the improvements they made in behavioral, emotional, and socials skills while participating in the program's treatment services. There was documentation in all three records the mental health and substance abuse discharge plan was discussed with the youth, parent/guardian, and the juvenile probation officer (JPO) during the exit conference. All three closed records contained documentation to support the MHSA discharge plan was provided to the youth, parent/guardian, and the JPO upon the youth's discharge.

3.08 Specialized Treatment Services (Critical)	Satisfactory Compliance
Specialized treatment services shall be provided in programs designated as "Specialized Treatment Services Programs" or are designated to provide "Specialized Treatment Overlay Services.".	

The program is designated as a substance abuse overlay services program and provides substance abuse services to the youth seven days a week. A review of five youth mental health and substance abuse records and group sign-in sheets, confirmed each youth has completed or is currently participating in the mental health and substance abuse groups provided by the program. Specifically, all five youth were attending the program's substance abuse group entitled, 7 Challenges.

A review of the program's therapists' caseload lists indicated none of their caseloads exceeded sixteen youth. Observations of three separate substance abuse group sessions confirmed each group had less than fifteen youth participating. As part of the specialized substance abuse services at the program, youth are randomly drug tested throughout their stay. A review of five youth records confirmed each youth received random drug testing. Two of the random tests indicated the youth tested positive for illegal substances; however, the program documented on the drug testing form the youth was on medication(s) which resulted in the positive test. A review of the five youth records also confirmed each youth was receiving individual, group, and family therapy as outlined in their treatment plan.

During an interview the DMHCA indicated they are a registered play therapist. The DMHCA indicated they use items such as stress balls, play toys, stuff animals, and fidget spinners to help the youth adjust to therapy and be open during the play therapy sessions. The DMHCA also indicated the program provides group services to the youth such as aggression replacement therapy, Impact of Crime, and Council for Boys and Young Men. The DMHCA indicated the program provides suicide assessments, crisis assessments, individualized therapy, family therapy, and psychiatric services. An interview with the executive director (ED) confirmed the program is designated to provide substance abuse overlay services (SAOS) and provides substance abuse services by having youth participate in the curricula, 7 Challenges.

3.09 Psychiatric Services (Critical)	Failed Compliance
Psychiatric services include psychiatric evaluation, psychiatric consultation, medication management, and medical supportive counseling provided to youth with a diagnosed DSM-IV-TR or DSM-5 mental disorder and each youth receiving psychotropic medication in the program as set forth in Rule 63N-1, F.A.C. ****Tele-psychiatry is not currently approved for use in Residential Programs****	

The provider Circle of Care (COC) provides the program with an advance practicing registered nurse (APRN) who is certified in nurse practitioner and appears to provide psychiatric services to the youth at the program. The APRN has a collaborative agreement between themselves, a supervising psychiatrist, and a secondary physician. A review of the Department of Health Medical Quality Assurance license website revealed the APRN's license is clear and active in the State of Florida expiring on April 30, 2020. The APRN's specialty certification is as a family nurse practitioner and not in the field of psychiatry.

A review of the supervising psychiatrist's license revealed they have a clear and active license in the State of Florida expiring on January 31, 2022. A review of the secondary physician's license revealed they have a clear and active license in the State of Florida and expiring on January 31, 2022. An interview with the designated mental health clinician authority, indicated the supervising psychiatrist and the secondary physician never come to the program to provide services to the youth at the program. The collaborative agreement also indicates the APRN functions will be performed under the general supervision of the supervising psychiatrist; however, during the annual review the program or COC provider was unable to provide any supervision received by the APRN from the supervising psychiatrist.
The contract between COC and the program indicates the APRN is required to be on-site bi-weekly and available for emergency consultation twenty-four hours a day, seven days a week. During an interview with the APRN confirmed the information above. During the interview, the APRN indicated there were no concerns about the healthcare provided at the program and they provide services such as initial psychiatric evaluations, psychotherapy, and see clients twice a month for medication management. A review of the sign-in sheets for the six months prior to the annual review revealed the APRN was on-site bi-weekly.

A review of five youth mental health and substance abuse records revealed four youth were referred for an initial diagnostic psychiatric interview. The remaining youth was not referred for an initial psychiatric interview as the youth had no mental health issues nor were they on any medication at the of admission. Three of the four initial psychiatric interviews were completed within fourteen days of the youth's admission. The fourth initial psychiatric interview was conducted twenty-days late due to the program waiting on a court order for the youth to receive the psychiatric services due to being under the care and custody of the Department of Children and Families. The youth received the initial interview as soon as the program received the court order approving the psychiatric services. All applicable initial psychiatric interviews documented the youth's medical, mental health, and substance abuse history, mental status examination, Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5), documented diagnosis, and treatment recommendations. Three of the initial psychiatric interviews resulted in the youth being prescribed psychiatric medications or ordered to continue their current medication regiment. The fourth initial psychiatric interview resulted in the youth being removed from their current psychiatric medication regiment. All initial diagnostic psychiatric evaluations were completed on the Department's form entitled Clinical Psychotropic Progress Note (CPPN) and it clearly identified the evaluations as the initial diagnostic psychiatric interview. All records

contained a fully completed page three of the CPPN. Three of the four applicable records required medication management reviews every thirty days with the APRN and all records reflected each youth received their required medication management review on-time without exception.

An interview with the APRN confirmed they provide medication management twice a month or more often as needed by the youth. The APRN indicated they are always on call and available by telephone, email, or text to review concerns with youth and clinical staff. The APRN also indicated medical problems are discussed and referred to the designated health authority as appropriate. Youth updates are discussed weekly or more often as needed with the treatment team.

3.10 Suicide Prevention Plan (Critical)	Satisfactory Compliance
The program follows a suicide prevention plan to safely assess and protect youth with elevated risk of suicide in the least restrictive means possible, in accordance with the Rule 63N-1, Florida Administrative Code.	

The program has a comprehensive suicide prevention plan detailing the program's procedures in the event of a suicide incident. The suicide prevention plan was recently reviewed and approved by the designated mental health clinician authority (DMHCA), advance practicing registered nurse (APRN), and the executive director on January 27, 2020. The program's suicide prevention plan includes identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, and immediate staff response, and a review process.

3.11 Suicide Prevention Services (Critical)	Satisfactory Compliance
Suicide Precautions are the methods utilized for supervising, observing, monitoring, and housing youth identified through screenings, available information, or staff observations as having suicide risk factors. *Any youth exhibiting suicide risk behaviors shall be placed on Suicide Precautions (Precautionary Observation or Secure Observation), and a minimum of constant supervision.* *All youth identified as having suicide risk factors by screening, information obtained regarding the youth, or staff observations shall be placed on Suicide Precautions and receive an Assessment of Suicide Risk.*	

The program has a suicide prevention plan which outlines the program's process for providing suicide prevention services to the youth at the program. The program's policy indicated each youth will be screened for suicide risk upon admission using a suicide risk form and each youth identified as at risk of suicide will receive an Assessment of Suicide Risk (ASR). A review of the program's completed ASR forms and Follow-up ASR forms indicated the program is utilizing the Department's Mental Health and Substance Abuse (MHSA) forms. The program has three suicide response kits and observations confirmed they all contained a knife-for-life, wire cutters, and needle nose pliers. One response kit is in the medical office, the second kit is in the youth dormitory area, and the third is in the education building. Five staff were interviewed on the location of the program's suicide response kits. Four staff indicated the program has three suicide response kits located in medical, education building and the dormitory area. The fifth staff indicated the kits are in administration, medical, and education. The five interviewed staff

stated they would do and all staff indicated they would notify mental health in the event a youth expressed suicidal ideations. Three staff further indicated they would place the youth on constant sight and sound and document supervision.

A review of five youth mental health and substance abuse records revealed all youth received a suicide intake screening and an ASR upon their admission to the program. Each record also indicated the youth was placed on constant supervision until the ASR was completed. All five admission ASRs were completed by a licensed professional. All five ASRs indicated the youth was not at risk for suicide and were all placed on standard supervision after the licensed professional confirmed with the executive director (ED). All admission ASRs were completed correctly and signed by the ED and the licensed professional, as the person completing the form. All admission ASRs indicated the youth's parent/guardian and juvenile probation officer (JPO) were notified the program completed an ASR on each youth and the youth were found not to be at risk of suicide. A review of the Department's Juvenile Justice Information System (JJIS) alert database indicated a suicide alert was entered into the system for all youth when they were placed on PO and the alert was closed when the youth were placed back on standard supervision. Documentation supported one of the five youth placed on PO was documented in the program's logbook. The logbook entries indicated when the youth was placed on PO and when the youth was placed on standard supervision. The program could not locate the program logbooks for July 30, 2019 through December 5, 2019; therefore, the team was not able to validate if the remaining four youth's precautionary observation and removal was noted in the facilities logbooks.

None of the five reviewed records contained documentation the youth were placed on any type of elevated status after the admission process. The program did not have any youth who required a follow-up ASR. The program also does not utilize secure observation; therefore, the reviewer was not able to review documents related to secure observation placements.

3.12 Suicide Precaution Observation Logs (Critical)	**Satisfactory Compliance**
Youth placed on suicide precautions shall be maintained on one-to-one or constant supervision. The staff member assigned to observe the youth shall provide the appropriate level of supervision and record observations of the youth's behavior at intervals of thirty minutes, at a minimum.	

A review of five youth individualized mental health and substance abuse records revealed all youth were applicable for suicide services upon admission. A review of the records revealed each youth had one precautionary observation (PO) log completed for the duration of their stay on suicide precautions. A review of the PO logs revealed the program is utilizing the Department's Mental Health and Substance Abuse form entitled, Suicide Precautions Observation Log. While each youth was on elevated status, they were maintained on the appropriate level of supervision and the logs contained staff observations of the youth in real time and there were no lapses. All PO logs documented supervision of the youth in thirty-minute intervals. None of the logs contained warning signs documented by the staff. All PO logs were reviewed and signed by the shift supervisor and licensed professional. All PO logs had designated safe housing areas noted on the form indicating where in the program the youth could be while on PO status. An interview was conducted with the five youth who were placed on PO indicated the staff always stayed with them while they were on PO and the staff never left them alone.

3.13 Suicide Prevention Training (Critical)	Satisfactory Compliance
All staff who work with youth shall be trained to recognize verbal and behavioral cues indicating suicide risk, suicide prevention, and implementation of suicide precautions.	

The program has a policy and procedures in place outlining staff training in suicide prevention and intervention. A review of five in-service training records and five pre-services training records revealed all staff received the required six hours of suicide training.

A review of the program's mock suicide drills confirmed the program conducted drills at a minimum of, quarterly on each shift, except for the second shift drill in first quarter of the year. The mock suicide drills conducted since the last annual compliance review were reviewed to ensure all staff who have direct contact with youth participated in at least one quarterly drill semi-annually. A review of the drills indicated all but two staff participated in a mock suicide drill semi-annually. The two staff did participate in one drill during the review period but lacked the second drill to meet the semi-annual requirement. All reviewed drills contained all required elements and staff who did not participate in a specific drill had the opportunity to review the drill scenario at staff meetings. During an interview with the executive director (ED) indicated all drills are performed quarterly on each shift which includes mock emergency response drills to suicide attempts or self-inflicted injury.

3.14 Mental Health Crisis Intervention Services (Critical)	Satisfactory Compliance
Every program shall respond to youth in crisis in the least restrictive means possible to protect the safety of the youth and others, while maintaining control and safety of the facility. The program shall be able to differentiate a youth who has an acute emotional problem or serious psychological distress from one who requires emergency services. A youth in crisis does not pose an imminent threat of harm to himself/herself or others which would require suicide precautions or emergency treatment.	

The program's mental health crisis intervention plan was recently reviewed and approved by the executive director (ED) and the designated mental health clinician authority on January 27, 2020. The program's mental health crisis intervention plan addresses notification and alert system, means of referral, to include youth self-referral, communication, supervision, documentation, and review of the crisis.

3.15 Crisis Assessments (Critical)	Satisfactory Compliance
A Crisis Assessment is a detailed evaluation of a youth demonstrating acute psychological distress (e.g., anxiety, fear, panic, paranoia, agitation, impulsivity, rage) conducted by a licensed mental health professional, or by a non-licensed mental health clinical staff person working under the direct supervision of a licensed mental health professional, to determine the severity of youth's symptoms, and level of risk to self or others. When staff observations indicate a youth's acute psychological distress is extreme/severe and does not respond to ordinary intervention, the program director or designee shall be notified of the crisis situation and need for crisis assessment. A Crisis Assessment is to be utilized only when the youth's crisis (psychological distress) is not associated with suicide risk factors or suicide risk behaviors. If the youth's behavior or statements indicate possible suicide risk, the youth must receive an Assessment of Suicide Risk instead of a Crisis Assessment.	

The program has a policy and procedures in place for the completion of a crisis assessment if a youth is in psychological distress. A review of five youth mental health and substance abuse records revealed none of the youth were applicable for the completion of a crisis assessment. The program provided one additional youth record which was applicable for the completion of a crisis assessment. The program utilized the Department's Mental Health and Substance Abuse (MHSA) form, entitled, Crisis Assessment when they completed the assessment. The crisis assessment contained the reason for the assessment, a mental status examination and interview, determination of danger to self and others, initial clinical impression, supervision recommendations, treatment recommendations, and recommendations for follow-up. After the completion of the crisis assessment, the youth was maintained on mental health alert. The crisis assessment was completed by a licensed clinician and completed within two hours of the incident. The licensed professional maintained the youth on close supervision for several hours after the completion of the crisis assessment. The licensed professional then conducted a mental status examination with the youth and placed the youth on standard supervision. A review of the Department's Juvenile Justice Information System (JJIS) alert database indicated a suicide alert was entered into the system instead of a mental health alert; however, the alert did indicate the youth was in crisis, placed on precautionary observation, placed on close supervision, and then released to standard supervision. Documentation on the crisis assessment indicated the youth's parent/guardian and juvenile probation officer (JPO) was notified of the youth's crisis and placed on elevation supervision.

3.16 Emergency Mental Health and Substance Abuse Services (Critical)	Satisfactory Compliance
Youth determined to be an imminent danger to themselves or others due to mental health and substance abuse emergencies occurring in facility require emergency care provided in accordance with Rule 63N-1 Florida Administrative Code and the facility's emergency care plan.	

The program has an emergency mental health and substance abuse service plan which outlines the care for youth in imminent danger to themselves or others due to mental health or substance abuse emergencies. The program's emergency mental health and substance abuse service plan was recently reviewed and approved by the designated mental health clinician authority (DMHCA) and the executive director on January 27, 2020. The program's plan contains procedures for immediate staff response, notifications, communication, supervision of youth, authorization to transport for emergency services, transportation for emergency mental health and substance abuse evaluation and treatment, documentation, training requirements, and a review process which meets all elements. A review of five pre-service training records

and five in-service training records indicated all staff received training on the program's emergency mental health and substance abuse services.

3.17 Baker and Marchman Acts (Critical)	**Satisfactory Compliance**
Individuals who are believed to be an imminent danger to themselves or others because of mental illness or substance abuse impairment require emergency mental health or substance abuse services.	

The program did not utilize a Baker Act or Marchman Act procedure during the review period; therefore, the indicator rates as non-applicable.

Standard 4: Health Services

4.01 Designated Health Authority/Designee (Critical)	Satisfactory Compliance
The Designated Health Authority (DHA) shall be clinically responsible for the medical care of all youth at the facility.	

The program has a contract with Brevard Health Alliance to provide medical services. The medical doctor serves as the designated health authority (DHA) and specializes in pediatrics and holds an unrestricted license to practice in Florida, with an expiration date of January 31, 2021. The DHA only delegates duties to the advanced practice registered nurse (APRN) which also specializes in pediatrics and holds an unrestricted license in Florida, with an expiration date of January 31, 2021. The provider Circle of Care (COC) provides the program with an APRN who is certified in nurse practitioner and appears to provide psychiatric services to the youth at the program. The APRN has a collaborative agreement (CPP) between themselves, a supervising psychiatrist, and a secondary physician. A review of the Department of Health Medical Quality Assurance license website revealed the APRN's license is clear and active in the State of Florida expiring on April 30, 2020. The APRN's specialty certification is as a family nurse practitioner and not in the field of psychiatry. A review of the sign-in and out log confirmed the DHA has been on-site for a minimum of two hours weekly, every seven days from September 2019 until February 2020. The DHA interview and facility operating procedures confirmed the DHA is available by telephone twenty-four hours a day, seven days a week regarding youth medical needs, acute medical concerns, emergency care, and coordination of off-site care. The DHA is responsible for all administrative duties regarding the medical department and APRNs are not utilized by the program.

4.02 Facility Operating Procedures	Satisfactory Compliance
The program shall have Facility Operating Procedures (FOP) for all health-related procedures and protocols utilized at the facility.	

The program has a policy and procedures signed and dated by the designated health authority (DHA) and executive director. The nursing staff signed the cover page on all facility operating procedures (FOPs). there were no newly hired healthcare personnel during the review period. The cover page with the nursing staff indicates they have read the FOP's and any new policies.

4.03 Authority for Evaluation and Treatment	Satisfactory Compliance
Each program shall ensure the completion of the Authority for Evaluation and Treatment (AET) authorizing specific treatment for youth in the custody of the Department.	

The program has a policy and procedures in regard to youth admitted into the program have a signed Authority for Evaluation and Treatment (AET) form. A current AET, signed and dated by the parent/guardian, and witnessed by a Department representative was present in each of the five youth individual healthcare records (IHCRs) reviewed. The AETs were stamped "copy" on each page of the consents. None of the five reviewed records were applicable IHCRs for youth in the custody of the Department of Children and Families. The AET was located in each youth IHCR. The nurse reported if there is no current AET or none at all, the nurse, case management, or director of case management will contact the youth juvenile probation officer (JPO) to request a new AET to be signed by the parent/guardian.

4.04 Parental Notification/Consent	Satisfactory Compliance
The program shall inform the parent/guardian of significant changes in the youth's condition and obtain consent when new medications and treatments are prescribed.	

Each of the five youth individual healthcare records (IHCRs) contained the required verbal notifications for medications or treatments with a witness verifying the verbal consent documented in the chronological progress notes. One of the five youth is eighteen years of age and did not require a verbal or written parent/guardian notification. None of the youth reviewed are in the care of the Department of Children and Families. In addition, none of the IHCR's were applicable for religious exemption nor did the parent/guardian refuse to consent to vaccinations. All written parent/guardian notifications were mailed within the required time frame with the exception of three instances. One of the records had two clinical psychotropic progress notes (CPPN), as required. One of the IHCR's had five CPPN's, one was completed within fourteen days of admission and the remaining four were completed within the thirty day time frame. None of the reviewed IHCR's were in the care of the Department of Children and Families (DCF) and required immunizations. The immunizations were documented in each of the five IHCR's on the day of the admission and confirmed by Florida Shot records to meet the Center for Disease Control (CDC) guidelines. The nurse reported, as soon as there is a change in the youth's health status, the youth is prescribed a medication or over the counter. If a medication is discontinued, the dose of a youth's medication is changed significantly or the youth is transported "off-site" for any medical or dental reasons, the nurse fills out the correct parental/guardian notification form to the parent/guardian, after notifying them verbally. This form notifies the parent/guardian of any changes in health status, medication, dosages, or injuries needing to be treated off-site and is mailed out to the parent/guardian the same day or the next day.

4.05 Healthcare Admission Screening and Rescreening Form (Facility Entry Physical Health Screening Form)	Satisfactory Compliance
Youth are screened upon admission for healthcare concerns which may need a referral for further assessment by healthcare staff.	

A Facility Entry Physical Health Screening (FEPHS) was completed for each of the five youth individual healthcare records (IHCRs) reviewed on the day of admission. One of the five IHCRs was applicable for rescreening's. An additional two youth records were provided by the program for review. Each of the three youth IHCRs were reviewed for healthcare admission rescreening when a change in the physical custody of the youth had occurred. All three IHCRs were completed by the registered nurse (RN) within twenty-four hours of re-entry to the program, as required. All FEPHS forms were signed and dated by the RN conducting the rescreening. The nurse reported, the nurse on duty at the time of the youth's intake completes the FEPHS. The form may be filled out by a staff member but a RN must review the form within twenty-four hours of the youth's admission to the program.

4.06 Youth Orientation to Healthcare Services/Health Education	Satisfactory Compliance
All youth shall be oriented to the general process of health care delivery services at the facility.	

Five youth individual healthcare records (IHCRs) were reviewed for orientation to the program's healthcare system. Topics to be included are listed in the facility policy and procedures and are discussed with the youth on day of admission. The five IHCRs contained all required topics and

were documented on each of the Healthcare Education Records. Healthcare contacts were located in the front of each IHCR and were found to be accurate.

4.07 Designated Health Authority (DHA)/Designee Admission Notification	Satisfactory Compliance
A referral to the facility's Physician, PA, or ARNP shall be made for youth who are admitted with known or suspected chronic conditions not requiring emergency treatment on admission.	

The designated health authority (DHA) was notified by telephone on the day of admission for chronic conditions, medications, and allergies for each of the five youth individual healthcare records (IHCRs) reviewed. None of the five reviewed IHCRs required emergency care at the time of admission. The program has a procedure and policies in place for admission notifications and all notifications to the DHA were documented on the chronological progress notes.

4.08 Health-Related History	Satisfactory Compliance
The standard Department Health-Related History (HRH) form shall be used for all youth admitted into the physical custody of a DJJ facility.	

The program has a policy and procedures to address the completion of Health-Related History (HRH) upon admission to the program. Five youth individual healthcare records (IHCRs) were reviewed and had the standard Department HRH form completed and signed by the registered nurse on the day of admission. The designated health authority (DHA) documented the review of the HRH by utilizing the checkbox on the Comprehensive Physical Assessment (CPA) indicating the HRH form was reviewed. One reviewed HRH had two questions blank on page one and the remaining HRH had three questions blank on page three. The remaining three HRH's were filled out in entirely. The nurse reported, the licensed nurse on duty or the DHA completes the HRH within seven days of the youth's admission to the facility.

4.09 Comprehensive Physical Assessment/TB Screening	Satisfactory Compliance
The standardized Comprehensive Physical Assessment form shall be used for all youth admitted into the physical custody of a DJJ facility.	

The program has a policy and procedures which requires the completion of a new or updated Comprehensive Physical Assessment (CPA) and tuberculosis (TB) screening. Five youth individual healthcare records (IHCRs) were allfound to have a CPA completed by the designated health authority (DHA) within the required seven day time frame. All elements of the CPA were filled out as required and the youth signed any portion of the CPA which was refused along with a signed refusal form. All five CPAs included documentation of a completed TB test within the past year. Medical grades were accurately documented on the CPAs as required. One of the five IHCR's did not have the chronic condition at the time of admission recorded on the problem list. The nurse reported, the TB screening is completed on the Facility Entry Physical Health Screening form which screens youth to identify if they have been exposed to someone with TB or having symptoms of a TB infection.

4.10 Sexually Transmitted Infection/HIV Screening	Satisfactory Compliance
The program shall ensure all youth are evaluated and treated (if indicated) for sexually transmitted infections (STIs) and HIV risk factors.	

The program has a policy and procedures in regard to sexually transmitted infection screening and human immunodeficiency virus (HIV) screening. Each of the reviewed five youth individual healthcare records (IHCRs) utilized the sexually transmitted infections (STIs) screening form. All five youth were referred for HIV testing and the referrals are documented on the STI screening forms. Testing is conducted by a certified HIV counselor with the Florida Department of Health for youth with consent. The five IHCRs refused HIV testing on the Department's HIV consent form and the consents are located in the IHCRs. The program does not include HIV status as part of the internal alert system. Youth interviews indicated all youth believe they can request HIV testing.

4.11 Sick Call Process	**Satisfactory Compliance**
All youth in the facility shall be able to make Sick Call requests and have their complaints treated appropriately through the Sick Call system. The program shall respond appropriately, in a timely manner, and document all sick call encounters as required by the Department. All youth in room restriction/controlled observation shall have timely access to medical care, as required by Rule.	

The program maintains a policy and procedures to ensure youth can make sick call requests and have their complaints treated appropriately through the program's sick call system. The program has two scheduled sick call times daily, seven days a week. The sick call request forms are available to the youth in the day room and a locked sick call box with an envelope top is mounted on the wall for the youth to place the request forms in. A schedule with the sick call hours was posted both in the day room and on the outside of the door to the medical clinic. Two of the five interviewed youth reported being seen immediately. One reported within one day and the remaining two youth reported never submitting a sick call request. One youth sick call was observed on February 12, 2020 and was conducted by the Registered Nurse. The youth complained of mild pain and swelling of the right hand from hitting the wall. The sick call request form was filled out completely with no blanks and logged on the sick call index and on the sick call log. The Registered Nurse followed the protocol the program has in place and administered Ibuprofen and applied a cold pack. The youth was advised to notify medical if his symptoms persisted or worsened.

The registered nurse (RN) interview indicated sick calls are only conducted by an RN or a supervisor if an RN is not on-site, within four hours of the request. A review of thirteen sick call request were submitted. Each of the thirteen reviewed requests contained all elements and there were no youth with similar complaints within a two week time frame. Follow-up care and referrals are documented on the progress notes when needed and the program does not utilize restricted housing. All sick call requests were logged on the sick call index and filed in the chronological progress notes in reverse chronological order. All requests were logged in the sick call logbook with the exception of one sick call request. All five IHCRs documented orientation to the sick call process was completed at the time of admission and documented on the education record. In the interviews, with five staff, they reported the nurse conducts sick call.

4.12 Episodic/First Aid and Emergency Care	**Satisfactory Compliance**
The facility shall have a comprehensive process for the provision of Episodic Care and First Aid.	

The program has a policy and procedures in place for the provision of episodic care and first aid care. Each of the five staff interviews indicated staff were aware they have the right and

responsibility to immediately call 9-1-1 at any time a youth's condition appears compromised. Healthcare and non-healthcare staff at the supervisory level have current training on the use of the epinephrine auto-injector documented and all healthcare staff have current cardiopulmonary resuscitation (CPR) certification.

The program has three automated external defibrillators (AEDs)located in the medical clinic, in the day room, and in education. Instructions are located with each AED. A list of emergency numbers includes the local poison control number which is posted in the staff office and in the medical clinic accessible to all staff, but inaccessible to youth. Episodic care is documented by licensed staff using the Subjective, Objective, Assessment and Plan (SOAP) format in the chronological progress notes and then logged in the episodic logbook.

Two youth records were applicable for episodic/first aid and emergency care. The program provided one additional record for review. In each of the three episodic events reviewed, all were logged in the episodic logbook. All required information including date/time of episodic care, nature of the complaint, findings of the person rendering care, treatment rendered, and the name and credentials of staff providing care was documented. Five first aid kits are maintained in the program and all five were sealed and contained all items approved by the designated health authority (DHA). Two first aid kits used for each of two program vans are secured in the medical clinic when not in use. One first aid kit is located in the day room, one is in the kitchen, and the remaining first aid kit is located in the medical clinic. The first aid kits are inspected and inventoried weekly which was documented on an inventory form every week for the past year. The contents are replenished as needed by the registered nurse (RN) and resealed with a numbered red tag.

Emergency medical drills are conducted on each shift quarterly as required by policy and procedures and cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED) were completed annually on each shift. Copies of all emergency medical drills from January 2019 to January 2020 were provided for review. The AEDs are checked monthly and logged on the AED check list. Copies of the AED checks from January 2019 to January 2020 were provided for review and were in compliance.

4.13 Off-Site Care/Referrals	**Satisfactory Compliance**
The facility shall provide for timely referrals and coordination of medical services to an off-site health care provider (emergent and non-emergent), and document such services as required by the Department.	

The program has a policy and procedures to address emergency care for the youth which includes the provision of off-site care. Five youth individual healthcare records (IHCRs) were reviewed and four were applicable for off-site care. Three youth went to the dentist and one youth went to the emergency room. All contained the off-site care reports which were reviewed and signed by the designated health authority (DHA) during the next site visit. In all instances, the youth received appropriate and timely follow-up care, as needed.

4.14 Chronic Conditions/Periodic Evaluations	Satisfactory Compliance
The facility shall ensure youth who have chronic conditions receive regularly scheduled evaluations and necessary follow-up.	

The program has a policy and procedures to address identifying and monitoring youth with a chronic illness. Five youth individual healthcare records (IHCRs) were reviewed and three were applicable for chronic periodic evaluations. Two IHCRs had one chronic condition each and one IHCR documented two chronic conditions. All were identified on the daily medical alert and on the chronic conditions roster maintained by the registered nurse (RN). The periodic evaluations for all applicable chronic conditions were documented on the progress notes by the designated health authority (DHA) within the required ninety-day time frame. The RN and DHA interviews indicated the chronic conditions and important medical issues are discussed weekly with the director of the program and signed by the DHA.

4.15 Medication Management	Limited Compliance
Medication shall be received, stored, inventoried, and provided in a safe and effective manner which shall be demonstrated by observation, review of documentation of procedures and processes.	

Two of the five youth individual healthcare records (IHCRs) were applicable for admission with medications. An additional record was provided by the program. Each of the three IHCRs had a Transfer of Medications form from a Department program and the medications were listed on the Facility Entry Physical Health Screening (FEPHS) form. The designated health authority (DHA) and psychiatrist were notified on admission of the youth's current medication and medications were continued until seen by the provider. Approved protocols are in place at the program for administration of over-the-counter (OTC) medications not covered by the AET. The program utilizes the standard Department's Medication Record (MAR) for documenting all medications and treatments. Each MAR reviewed clearly marked the start and stop dates of medications administered. There were no lapses noted on any of the MARs for the three youth currently on medication. Two of the five interviewed youth are not on medication and three youth reported the nurse provides their medication. The nurse reported, the program has a list of staff approved to assist with self- administration of medications which are shift leaders, director of case management, director of operations, and executive director. The nurse also confirmed the program utilizes the standard Department's Medication Record (MAR), which is printed and filled out by staff.

One IHCR had no side effects documented on the October 2019 MAR for three medications. The November 2019 MAR was missing side effects for two medications and the December 2019 MAR was missing side effects for two medications. There were no side effects documented on the second IHCR on the December 2019 MAR for one medication and the January 2020 MAR was missing side effects for three medications.

A list of trained non-healthcare staff at the supervisory level was provided for review and these staff are only utilized when a licensed healthcare provider is not on-site. A medication pass was observed for six youth and the registered nurse (RN) maintained the six rights of medication delivery/administration at all times. Refusals are clearly marked on the MAR and a refusal form is filled out when required. There are no standing psychotropic medication orders and there are no pro re nata (PRN) orders for psychotropic medications.

4.16 Medication/Sharps Inventory and Storage Process	Satisfactory Compliance
Any medical equipment classified as stock medications shall be secured and inventoried by using a routine perpetual inventory descending count as each sharp is utilized and disposed of or when the medication is utilized.	

The program has policy and procedures which outline the medication/sharps inventory and storage process. All sharps are secured in a locked cabinet and inventoried using a weekly and perpetual descending count as the sharps are utilized. Three sharps were counted with the register nurse (RN) such as syringes, suture removal kits, and staple removal kits. All counts were accurately reflected on the inventory form. Medications were secured in a locked medication cart in the medical clinic and two controlled substances were locked in a separate drawer behind a second lock. Both controlled substances were counted by two staff on each shift and documented on the youth's individual Controlled Medication Record.

Supervisory level non-healthcare staff have been trained in the delivery and oversight of medication self-administration and are only utilized if licensed healthcare staff is not on-site. The remaining doses after administration are recorded on the MAR for each medication were found to be accurate. Three randomly selected over-the-counter medications (OTCs) were counted and all counts were accurately documented on the inventory form. All controlled medications are destroyed with the nurse and the pharmacist consultant who is on-site once monthly. Routine medications are destroyed with prescription (RX) destroyer by two licensed nurses and documented on a Destruction of Medication form. A review of January 2019 to January 2020 logs of inventoried sharps and stock OTC medications was provided for review and there were no lapses or discrepancies noted. The nurse reported, all medications are securely stored in a locked cart designed for storage of medication with different medication forms stored separately and have a weekly perpetual inventory log.

4.17 Infection Control – Surveillance, Screening, and Management	Satisfactory Compliance
The program shall have implemented Infection Control procedures including prevention, containment, treatment, and reporting requirements related to infectious diseases, as per OSHA federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines. The Comprehensive Education Plan is to include pre-service and in-service training for all staff. Education for youth infection control shall also be provided at the time of intake and subsequently when the need is identified.	

The program has a policy and procedures in place for infection control and a combined infection/exposure control plan which was reviewed and signed by the designated health authority (DHA), the program director, and three nurses in January 2020. The plan includes procedures for all infection types and a process for needle stick exposure is included. A copy of the infection/exposure control plan is stored in a binder in the staff office and is accessible to all staff. Staff are offered the Hepatitis B vaccine at the time of hire. Youth receive infection control training on the day of admission which includes bloodborne pathogens and Standard Universal Precautions. The five youth individual healthcare records (IHCRs) reviewed had the training documented on the Health Education Records in their IHCRs. All staff received Infection/exposure control training during pre-service which includes prevention of bloodborne pathogens and locations of personal protective equipment (PPE). The program has not experienced an occupational exposure from January 2019 to January 2020. A Central Communications Center (CCC) call was made for one youth who was transported to the emergency room and diagnosed with Influenza Type A. No further youth contracted this virus

and there were no reportable infectious outbreaks requiring notification to the Florida Department of Health or the Center for Disease Control (CDC).

4.18 Prenatal Care/Education	**Satisfactory Compliance**
The program shall provide access to prenatal care for all pregnant youth. Health Education shall be provided to both youth and staff.	

This is an all-male program; therefore, this indicator rates as non-applicable.

Standard 5: Safety and Security

5.01 Youth Supervision	Satisfactory Compliance
Program staff shall maintain active supervision of youth, including interacting positively with youth, engaging in a full schedule of constructive activities, closely observing behavior of youth and changes in behavior, and consistently applying the program's behavior management system (BMS). Program staff can account for the whereabouts of youth under their supervision at all times.	

The program has policy and procedures addressing youth supervision. The staff-to-youth ratios required by contract for the program are one staff for every eight youth during awake hours, one staff for every ten youth during sleep hours, and one staff for every five youth for off-campus activities. Observations of staff supervision of youth were made during the annual compliance review, which included movements, meals, school, outside recreation, and when youth were in their dorms. Staff were observed to be appropriately positioned to supervise youth, maintain active supervision of youth, and interact with youth in a professional manner. The nurse was observed escorting a youth from the classroom to the nursing office located in the administration office, the nurse is Protection Action Response (PAR) certified; however, is not to be involved in direct supervision of youth. This was immediately rectified upon notification to the program. The required staff-to-youth ratio was actively maintained at all times. When asked, staff were aware of the number of youth under their supervision. Youth head counts were observed, resulting in an accurate count each time. Procedures are in place to reconcile head counts, if needed.

5.02 Comprehensive and Consistent Implementation of the Behavior Management System and Staff Training	Satisfactory Compliance
The program shall have a detailed written description of the collaborative behavior management system (BMS). The written description is conspicuously posted and provided in a resident handbook to allow easy access for youth, including rules governing conduct and positive and negative consequences for behavior including while in the classroom. *All staff shall be trained in the behavior management system (BMS) utilized at the program.*	

The program has a written policy and procedures which outlines the program's behavior management system (BMS). The program utilizes a six-level BMS. The levels are: recruit, seaman, second class, first class, chief, and ensign. Each youth can earn up to 612 points a week, points are tallied on Saturdays for the previous seven days, with the results being used to compile a chart in order of the highest earning youth to the least, called a cap chart. The youth earning the top five points in the week are allowed privileges in addition to their rank privileges which include activities such as first served at meals and participation in an off campus trip the following week. The BMS indicates if the youth's behavior does not show progress or warrant progress, the youth may have his individualized performance plan revised to address his behaviors. Each level has identified privileges, which include a progressively later bed time, kitchen privileges, movie night with a special treat once or twice a month, or scheduled outings, if behavior permits. The program's policy does specify the four-to-one ratio regarding the recognition of accomplishment and positive behaviors. The BMS is designed to maintain order and security, provide positive and negative consequences, discuss alternative behaviors, provide opportunities for staff and youth to discuss the impact of their behavior on others, provide opportunities for positive reinforcement, and provide opportunities for youth to explain their behavior. The program's BMS outlines levels of intervention, to include a friendly non-

verbal phase, a concern non-verbal phase, a helpful verbal phase, request for staff and/or youth support, staff intervention, and if needed, physical restraint. The BMS is clearly posted in the multi-purpose area, or pavilion, and is included in the youth handbook. A review of five youth case management records confirmed the BMS was reviewed with each youth during orientation. A review of staff training records revealed each staff had been trained in the BMS including the education staff who are employed by the program.

Observations during the annual compliance review included staff addressing behaviors with youth and youth being given an opportunity to explain their behavior. Five interviewed youth were able to explain the difference between each level of the BMS and how to move from level to level. When asked about consequences used, youth reported they can have points deducted, not advance in level, have goals added, or possible restriction of outside activities. Youth stated the BMS includes a disciplinary work detail to document inappropriate behavior including such acts as being out of supervision, horseplay, behavior infractions, destruction of property, use of profanity, fighting, theft, and disrespect. Each youth reported rewards utilized at the program include outings, special food on Monday or Friday, and fast food or other outside food choices. Five staff interviews indicated they know and understand how to implement the BMS. An interview with administration indicated a point card is used giving each youth the chance to earn one to three points twice each period. At the end of the week, youth are afforded privileges based on the amount of points earned, earn tokens for meeting behavior goals, and can exchange the tokens for items in the token economy store.

5.03 Behavior Management System Infractions and System Monitoring	**Satisfactory Compliance**
The program's behavior management system (BMS) is designed to maintain order and security, provide constructive discipline and a system of positive and negative consequences to encourage youth to meet expectations for behavior, provide opportunities for positive reinforcement and recognition for accomplishments and positive behaviors, promote dialogue and peaceful conflict resolution, and minimize separation of youth from the general population. *Supervisors shall monitor staff implementation of the behavior management system (BMS), and ensure the use of rewards and consequences are administered fairly and consistently in application among all staff.*	

The program policy and procedures address the behavior management system (BMS), which includes consequences and sanctions. The program does not use room restriction. The program's policy does address a protocol where staff are provided feedback regarding their implementation of the BMS and maintaining the required four-to-one ratio of positive-to-negative. An interview with the facility administrator and five staff validated they are provided feedback through review of point cards, verbal communication, and shift briefings. In addition, a sample of job descriptions reviewed clearly showed each staff's job function included providing rewards and consequences as prescribed in the program's BMS. A review of five staff annual evaluations included a review of the staff's use of the BMS and provided redirection and coaching to youth who exhibit inappropriate behavior.

Five youth interviewed reported they are never allowed to punish other youth. One youth reported staff are not consistent in the use of the BMS rated the BMS as poor. One youth reported the BMS as being fair, two reported good and one reported the BMS is very good.

An interview with the executive director reflected the BMS is monitored by the supervisors and the director of operations weekly. The executive director stated level promotions are posted when a youth's level changes on the rank board.

5.04 Ten-Minute Checks (Critical)	Failed Compliance
A residential commitment program shall ensure staff observe youth at least every ten minutes while they are in their sleeping quarters, either during sleep time or at other times, such as during an illness or room restriction. Staff shall conduct the observations in a manner to ensure the safety and security of each youth and shall document real time observations manually or electronically.	

The program policy and procedures state ten-minute checks will be completed anytime youth are in their dorm sleeping. Youth sleeping dorms are an open dorm concept with youth sleeping in bunk beds, staff positioned at the front door, and when over twelve youth a second staff positioned at the back of the dorm by the bathroom. The program maintains video footage of ten-minute checks for a period of thirty days. Video and ten-minute check sheets for five randomly selected days were reviewed. The ten-minute check logbooks (overnight logbook) for each night documented staff checked on youth in their room every nine to ten minutes for the entire night. The staff document half-hour skin checks in the program logbook and were verified in the current logbook dated December 6, 2019 to present; however, a review of video could not verify the documented check time occurred due to staff not getting up and completing a ten-minute skin check on each youth, visual checks are completed. Five staff were interviewed, and all reported youth are checked every ten minutes when in their rooms.

5.05 Census, Counts, and Tracking	Satisfactory Compliance
The program ensures youth are accounted for at all times through a system of physically counting youth at various times throughout the day. *The program shall conduct and document resident counts minimally at the beginning of each shift, after each outdoor activity, and during emergency situations such as escapes or riots.* *The program shall maintain a chronological record of events as they occur, or, if an event disrupts the safety and security of the program, as soon as is feasible after order has been restored.* *The program tracks daily census information, including, at a minimum, the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program. If at any time staff cannot account for the whereabouts of any youth, or discrepancies are found between resident counts and census information, the program reconciles immediately and takes follow-up action as needed.*	

The program policy and procedures address youth census, counts, and tracking. The program documents ten-minute checks in the overnight logbook which were reviewed for the past six months. A review of the logbook for the dates of March 3to July 5, 2019 indicated the documentation met the requirements with a few write overs. A review of the current logbook dated December 6, 2019 to present indicated the documentation met the requirements with the exceptions of a few write overs. The missing logbook covers the period of July 30 to December 5, 2019 four months of the required six months to review. The logbooks reviewed documented admissions, releases, and when youth were taken off-site. Counts were documented in the

logbooks at the beginning of each shift and every hour. Logbooks showed proper counts were taken and cleared after a qualifying emergency and simulated drills. Observations confirmed counts were completed at the beginning of each shift and every hour. Two formal head counts were observed. Each observed count was controlled, accurate, and cleared without issues. Five staff were interviewed and all knew the process to reconcile a count, stating all movement stops until the count clears.

5.06 Logbook Entries and Shift Report Review	Failed Compliance
The program maintains a chronological record of events, incidents, and activities in a central log-book maintained at master control, living unit logbooks, or both, in accordance with Florida Administrative Code. The program ensures direct care staff, including each supervisor, are briefed when coming on duty.	

The program maintains a chronological record of events, incidents, and activities in a central logbook. The program is missing a logbook which covers the period of July 30 to December 5, 2019 which covers four months of the required six months to review. The program reported the missing logbook was lost during the time carpet was being installed in the area logbooks are maintained. A review of the logbook for the dates of March 3to July 5, 2019 indicated the documentation met the requirements with a few write overs. A review of the current logbook dated December 6, 2019 to present indicated the documentation met the requirements with the exceptions of a few write overs. The logbooks were bound with pages numbered. All entries were made with ink and there were no entries removed through erasure, whiteout, or other methods. Entries were legible and included the date, time, brief description of the event, including names of staff or youth, and the name and signature of the staff making the entry. The logbook documented head counts at the beginning of each shift and every hour after. Documentation of daily perimeter checks, as well as all youth movement can be found in the program-maintained logbook. Central Communications Center (CCC) incidents, since December 6, 2020, were logged in the logbook. The logbooks appeared to reflect all program activities. Shift briefings and reviews of previous shifts were noted in the logbooks and shift reports.

5.07 Key Control	Satisfactory Compliance
The program has a system in place to govern the control and use of keys including the following: • *Key assignment and usage including restrictions on usage* • *Inventory and tracking of keys* • *Secure storage of keys not in use* • *Procedures addressing missing or lost keys* • *Reporting and replacement of damaged keys*	

The program policy and procedures for key control addresses assignment of keys, tracking of keys, missing or lost keys, and reporting of and replacement damaged keys. Training on key control has been provided to staff. Visitors must turn in personal keys before entering the facility and receive a “chip” identifying the hook their keys are placed on. A visual inspection was made of the key storage location. The key control box in the main lobby contains visitor keys as program keys when not in use. Each key has an assigned identifying chip. The staff turn in their personal keys and receive their assigned facility keys for their shift from their supervisor, and then turn in the facility keys at the end of the shift to the supervisor. The supervisor of each shift

is responsible for assigning keys to staff and returning the keys back to staff, then handing the keys over to the next shift supervisor. The issuance of facility keys for each staff key is documented. There is a lock box which contains all spare/duplicate keys, restricted keys, emergency keys, and is secured in the director of operations office. All transport van keys are securely housed in the administration lockbox. A review of the key inventory found it accurately reflected the number of keys on each key ring. Staff who are assigned permanent issued keys have signed the keys they received. Five staff were interviewed and all knew the process for missing or damaged keys. Each staff knew the procedures for receiving and turning in assigned work keys and personal keys. Staff knew all visitors must turn in their personal keys and receive a chip prior to entry into the program. The director of operations and the assistant administrator, who both handle keys, were able to explain the key control process for staff and visitors.

5.08 Contraband Procedure	Satisfactory Compliance

The program's policy must address illegal contraband and prohibited items.

A program shall delineate items and materials considered contraband when found in the possession of youth, the list must include: sharps, escape paraphernalia, tobacco products, electronic or vaporless cigarettes, non-facility issued electronic equipment or devices, metals, personal non-facility issued cellular devices, unauthorized currency or coin(s), and non-facility issued keys. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its staff/youth.

The program shall document the confiscation of any illegal contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the program director or designee has the discretion to discard the item, return it to its original owner, mail it to the youth's home, or return it to the youth upon release. In all instances involving confiscation of illegal contraband, the program shall turn the item over to local law enforcement and a criminal report filed.

The program policy and procedures address contraband, to include the confiscation of contraband. Reviews of facility logbooks, youth search forms, and contraband logbooks were conducted to verify youth room and dorm searches were conducted. Logbooks included documentation of perimeter checks. All youth are provided a resident handbook at intake, which identifies the disposal of contraband by program staff or law enforcement, if needed. The youth handbook addressed and/or defines what is considered contraband. The executive director reported, the director of operations and executive director are notified of any illegal contraband; law enforcement is contacted and the items would be disposed of by law enforcement. Contraband, which is not illegal, is disposed of by director of operations by disposing the contraband in the trash.

Five youth records reviewed found the youth orientation procedures included a discussion of items considered contraband. The list specified the required prohibited items, such as personal cell phones, equipment, and/or electronic devices capable of taking pictures and/or audio/video recordings, which are prohibited in the secure area. The five records reviewed found the program did document contraband obtained from youth searches in the youth's point cards.

5.09 Searches and Full Body Visual Searches	Satisfactory Compliance
The program shall perform searches to ensure no contraband is being introduced into the facility.	

The program policy and procedures address searches and full body visual searches of youth. Observations of staff performing youth searches were conducted on several occasions when there was youth movement throughout the program. Searches were conducted by male staff (same gender as youth). Staff conducting the searches were respectful of youth during the searches. A review of youth case management records showed documentation youth full body visual searches were performed upon youth entry into the facility and each time of re-entry, when applicable. Full body visual searches were documented on a body chart and in the logbook. Five staff and five youth interviews were conducted. The staff reported only male staff conduct searches. Both youth and staff reported searches are conducted after activities and youth movement within the program.

5.10 Vehicles and Maintenance	Satisfactory Compliance
The program ensures any vehicle used by the program to transport youth is properly maintained, and maintains documentation on the use and maintenance of each vehicle. Each vehicle being used for transport of youth shall pass an annual safety inspection. Each vehicle used to transport youth is to be equipped with the appropriate number of seat belts, a seat belt cutter, a window punch, a fire extinguisher, and an approved first aid kit. Youth and staff wear seat belts during transportation, and youth are not attached to any part of the vehicle by any means other than proper use of a seat belt.	

The program currently has one van used for transportation of youth. Documentation reflected the vehicle received an annual safety inspection being completed on January 10, 2020. The vehicle's record documented a preventive maintenance form indicating when an oil and filter change occurred, a rotation and balance of the tires, and inspections of the brakes, hoses, cables, lights, horn, filters, fluids, seat belts, exhaust system, and the parking brake. Invoices for the vehicle were maintained by the program, documenting the service to the vehicles were completed. The vehicle was equipped with the appropriate number of seatbelts, a knife-for-life, which is utilized as a seat belt cutter, a window punch, fire extinguisher, and a first aid kit, which is maintained in the program, when not in use. Upon inspection, each vehicle was locked. Youth are not attached to any part of the vehicle by any means other than proper use of a seat belt. A transport was observed during the annual compliance review which verified the staff inspected the vehicle prior to departure, had the first aid kit, and a cellular phone for communication.

5.11 Transportation of Youth	Satisfactory Compliance
Appropriate minimum staff to youth ratio shall be maintained while youth are transported off facility grounds to ensure the safety and security of youth, staff, and the public.	

The program's policy and procedures addressing transportation of youth, includes the use of mechanical restraints for youth being transported. Driver license checks are conducted annually by the administrative assistant to ensure all staff have valid Florida driver's license. Transport vehicles are searched prior to transport and upon return to ensure no contraband is present. Staff take cellular phones on transports to allow for communication with the program. Staff do not transport youth in their personal vehicle and never allow youth to drive facility or personal vehicles. Observations of facility transport vehicles showed each of the van doors were locked

when not being used. Random staff vehicle checks confirm the vehicles were locked. Five staff were interviewed and were able to explain the program's transportation procedures.

5.12 Weekly Safety and Security Audits	Satisfactory Compliance
A program shall maintain a safe and secure physical plant, grounds, and perimeter.	

The program's policy and procedures address weekly safety and security audits. The policy indicates the director of operations is responsible for ensuring all aspects of the program are safe and secure for youth, staff, and visitors. The policy outlines any deficiencies identified are reviewed, as well as corrective action is developed and documented on the safety and security audit tool. An interview with the executive director confirmed the program has an internal process regarding the identification and tracking of deficiencies to ensure they are addressed by the program as outlined with their policy and procedures.

Documentation showed the program conducts a facility security audit and safety inspection on a weekly basis. Each inspection noted any concerns, comments, corrective action needed, and a corrective action date to be completed. Several of the inspection reports documented the completion date of previously identified concerns, and when the deficiencies were corrected. Each safety and security inspection was completed by the director of operations.

5.13 Tool Inventory and Management	Satisfactory Compliance
The facility shall have a tool management system ensuring youth do not use tools or equipment as weapons or security breaches.	

Inventories of the kitchen, and the maintenance tools were conducted. While reviewing the tool room, a random check from the official inventory list was conducted. No tools were found to be missing or damaged. All tools observed were clearly identified with a tool number. The shadow board clearly outlined all tools with an identification number for the tool placed there. The program only uses gardening tools on-site. All tools in the tool room were properly signed out and signed back in by staff when used. While reviewing the kitchen tools, no cooking tools or knives were noted as missing. Each tool/knife was properly labeled with a tool number and all were accounted for. All tools were properly stored in a locked cabinet behind a locked door. During the review of the program's tools, all tools were found to be secure and non-accessible to youth. Staff are trained on the safe use of tools, which is documented in the Department's Learning Management System (SkillPro). Five youth records were reviewed and each had documentation of safe use of tools training, which was completed during orientation.

5.14 Youth Tool Handling and Supervision	Satisfactory Compliance
There shall be procedures to ensure youth use tools safely and are supervised appropriately in order to prevent injuries to the youth, other youth, and staff.	

The program has a policy and procedures to address youth use of tools. Staff supervise youth at all times when youth use mops and/or brooms during cleaning activities, rakes, shovels or the posthole digger when completing outside work projects. Youth are only permitted to use the aforementioned tools. Risk assessments and reassessments are completed for each youth by the case managers and maintained in youth records. The risk assessment and reassessment include if youth are eligible to use tools. Five staff and five youth were interviewed. All staff and youth indicated the only tools youth may use are mops, brooms, and gardening tools.

5.15 Outside Contractors	Satisfactory Compliance
The program shall establish guidelines required for outside contractors, which includes information about tool control and restrictions.	

The program has a policy and procedures in place regarding outside contractors completing work at the program which includes who is responsible for providing approval if prohibited items are required to complete necessary work. The program maintains an outside contractor binder which includes sign-in sheets for each contractor. The sign-in sheet includes the vendor's name, tool sign-in, tool sign-out, staff responsible for checking tools, and a statement notifying contractors cellular phones and other recording devices are prohibited. The form did not include instructions for the contractor on tool restrictions, keeping youth out of the work area, or missing tool follow-up; however, during the annual compliance review observations confirmed outside contractors are always accompanied by program staff and youth are kept out of the work area. The program amended their form during the annual compliance review to include all items. Five invoices were reviewed and four were found in the contractor sign-in book which included all information on the form filled out. The one invoice which was not found in the binder was for an estimate and the program reported the contractor had not yet completed the work on-site.

5.16 Fire, Safety, and Evacuation Drills	Failed Compliance
The program shall conduct fire, safety and evacuation drills to ensure youth and staff are prepared for immediate implementation or mobilization in the event of an emergency or disaster.	

The program maintains a Continuity of Operations Plan (COOP) which outlines the frequency of fire, safety, and evacuation drills required to be completed by the program. A program tour found fire evacuation plans were posted throughout the program. In addition, documentation confirmed each of the program's fire extinguishers were inspected monthly by the program and annually by an outside provider. The program's COOP outlines the program is to conduct fire drills on each shift on a monthly basis and conduct other drill types periodically throughout the year. Documentation of drills completed during the annual compliance review found drills were conducted in fire, escape, and tornado/hurricane procedures. However, fire drills were not conducted on second shift in February, all three shifts in March, first shift in April, third shift in May, second shift in June, and first and second shift in July 2019. There were no drills conducted during the annual compliance review period on program disturbances, bomb threats, hostage situations, chemical spills, flooding, or terroristic threats/acts. The drill forms for all fire drills, all escape drills, and some of the weather drills did not include a brief scenario as required, only checkboxes to signify the location of the emergency and check whether certain actions were taken by the drill. An interview with the executive director confirmed escape and COOP drills are to be conducted quarterly on each shift and fire drills are to be conducted monthly on each shift. Five staff were interviewed and four reported they had participated in a weather and fire drill in the last twelve months, three reported participating in an escape drill, and one reported participating in a chemical spill drill. Five youth were interviewed and three reported they had been instructed on what to do in case of a fire, two of which specified drills are done monthly and one of which reported they had completed one or two drills while in the program. Two of the youth reported they had not been instructed on what to do in case of a fire, one of which said they had never been involved in a fire drill. The results of the interviews were shared with program administration.

5.17 Disaster and Continuity of Operations Planning	Limited Compliance
The program shall have a coordinated disaster plan and Continuity of Operations Plan (COOP) or one comprehensive plan incorporating both. The plan(s) shall provide for the basic care and custody of youth in the event of an emergency or disaster and continuity of the aforementioned, while ensuring the safety of staff, youth and the public. The plan shall be submitted to the regional director, or designee, for approval and signature. *A residential commitment program shall establish and maintain critical identifying information and a current photograph which are easily accessible to verify a youth's identity, as needed, during his or her stay in the program.*	

The program maintains a Continuity of Operations Plan (COOP) which is located in each of the program's three buildings and is accessible to staff. The COOP was reviewed and updated on April 9, 2019 and was approved by the Department on April 11, 2019. The COOP included a combined Emergency Disaster Preparedness Plan, addressed alternative housing plans, and all required information for new COOPs. The program maintains a hard-copy record for each youth in the event of an emergency which is easily accessible and located in the nurse's office. The hard-copy records did not include required information on each youth's juvenile probation officer (JPO), judge, state attorney, public defender, victim notification information, the youth's committing offense and judicial circuit, judge jurisdiction, and physical description of the youth. The executive director was interviewed and confirmed the location of the COOPs.

5.18 Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory Compliance
The program director or designee shall maintain strict control of flammable, poisonous and toxic items and materials and a complete inventory of all such items.	

The program's policy and procedures address the storage and inventory of flammable, poisonous, and toxic items and materials. The policy and procedures address issuance and accessibility, as well as identifies certain hazardous chemicals to only be handled by specifically identified personnel with proper training. All active, general cleaning chemicals for the kitchen and youth dorms were stored in a separate secure closet with complete and accurate inventory sign-out sheets. All surplus cleaning chemicals for the kitchen and youth dorms were securely stored in a storage closet in the kitchen, which is inaccessible to youth. All surplus chemicals were accurately inventoried with proper documentation indicating when surplus was taken. Safety Data Sheets (SDS) were maintained for each chemical along with an individualized chemical inventory sheet. A review was conducted of the secured outside storage closet, which contained all flammable chemicals, paints, oils, and miscellaneous chemicals, which were stored in a fireproof safety locker. The storage closet inventory sheet reflected an accurate account for all items in the inventory. All chemicals were found to be accurately accounted for with proper sign in/out sheets for utilization.

5.19 Youth Handling and Supervision for Flammable, Poisonous, and Toxic Items and Materials	Satisfactory Compliance
The program shall maintain strict control of flammable, poisonous, and toxic items and materials. *Youth shall not be permitted to use, handle, or clean dangerous or hazardous chemicals or respond to chemical spills. Youth shall not be permitted to clean, handle, or dispose of any other person's biohazardous material, bodily fluids, or human waste.* *The program shall establish and implement cleaning schedules, a pest control system, a garbage removal system, and a facility maintenance system which shall include maintenance schedules and timely repairs based on visual and manual inspections of the facility structure, grounds, and equipment, which shall be conducted bi-weekly, monthly, quarterly, semi-annually, yearly, and every three years, as prescribed in the Preventive Maintenance Checklist (RS 123, February 2019.*	

Program policy and procedures prohibit youth from handling flammable, poisonous, and toxic items. Procedures are in place for supervision of youth who assist in cleaning activities, requiring staff to maintain control of any cleaning agents used. The annual compliance review team observations and documentation reviewed found youth did not handle any toxic items. Biohazard spill kits are stored in both dorm sub controls. Five youth were interviewed and reported they do not have access to flammable, poisonous, and toxic items and materials.

5.20 Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory Compliance
The maintenance personnel, or other trained staff who have the safety equipment for diluting, handling, and disposing of hazardous waste and/or solid waste, shall be responsible for disposing of hazardous items and toxic materials.	

The program has a policy and procedures for the disposal of flammable, poisonous, and toxic items, which includes the safe disposal of caustic materials meeting Occupational Safety and Health Administration (OSHA) standards. The program has had no incidents of chemical spills for the annual compliance review period. Mop water and excess kitchen fluids are disposed in plumbing drains. The program utilizes a grease pit/trap to store all used cooking grease/oil until time for proper disposal. Materials are disposed of monthly if needed; however, the program has not had any materials to dispose of since the last annual compliance review. All Flammable, Toxic, Caustic and Poisonous items are labeled and kept in secure areas. An interview with the director of operations indicated chemical disposal practices were in accordance with disposal instructions listed on Safety Data Sheets (SDS). The executive director interview showed he was familiar with the program's process and practices for the disposal of flammable, toxic, caustic, and poisonous items.

5.21 Elements of the Water Safety Plan, Staff Training, and Swim Test (Critical)	Satisfactory Compliance

Programs choosing to participate in water-related activities shall develop and implement a water safety plan to ensure proper supervision and safety of the youth during water related activities. The plan shall also ensure staff are appropriately trained for each specific type of water activity.

Programs allowing youth to participate in water-related activities shall have a water safety plan addressing, at a minimum, safety issues, emergency procedures, and the rules to be followed during water-related activities, as follows:

- *Determination of the risk level for each participating youth, including whether or not the youth can swim, an assessment of swimming ability, and other factors to include age and maturity, special needs such as physical and mental health issues, and physical stature and conditioning;*
- *Type of water, such as pool or open water;*
- *Water conditions, such as clarity, turbulence, and bottom conditions;*
- *Type of activity, such as swimming, boating, canoeing, rafting, snorkeling, scuba diving, and shoreline and offshore activities to include fishing from a bank or pier, fishing while wading, or picnicking close to a body of water.*
- *Lifeguard-to-youth ratio and positioning of lifeguards;*
- *Other staff supervision; and*
- *Safety equipment needed for the activity, such as personal flotation devices when youth are in a boat, canoe, or raft, and availability of a lifeline during shoreline and offshore activities.*

Programs choosing to participate in water-related activities shall ensure staff are appropriately trained for each specific type of water activity.

Programs choosing to participate in water-related activities shall assess each youth's aquatic ability prior to participation in water-related programming.

The program has a policy and procedures within the water safety plan regarding staff appropriately trained for water related activities. The instructor must possess annual certification consistent with the American Red Cross or nationally accepted standards for the type of water in which the activity is taking place. A review of five personnel records found two staff completed the Lifeguard Aquatics Skills and are certified as a Life Guard by the American Red Cross. The certification provides these designated staff to supervise pool activities and open water aquatics activities. The program provided a comprehensive packet of information regarding the most recent water-related activities for review which includes: lifeguard certifications, youth swim test results, trip planning for swim practice, and photographs of the event. None of the five interviewed youth indicated they participate in water activities.

The program has a water safety plan for water-related activities. The plan requires all youth to be swim tested prior to participating in any water-related activities. The youth must be tested by instructors who possess certifications consistent with the American Red Cross or nationally accepted standards for the type of water in which the activity is taking place. The test includes an assessment of if the youth can swim and the level of their swimming ability. Factors also include age, maturity mental health issues and physical stature and conditioning. Swim Evaluation forms for youth during this annual review period were reviewed. Each form indicates the name of the person conducting the test, if the youth passed the swim test, and the youth's

swim ability level. Five youth reported not participating in water activities since being in the program.

5.22 Visitation and Communication	**Satisfactory Compliance**
The program allows visitation and communication for youth while in the program.	

The program has a policy and procedures which outlines the provision of visitation and communication for youth while in the program. The policy outlines youth have visitation every other Sunday, which was confirmed through the posted visitation schedule, youth are allowed to correspond with approved parties by mail and may use the telephone as determined by the behavior management rank and program schedule. The policy further outlines alternative arrangements can be made with parent(s)/guardian(s) for visitation, if needed. The visitation log, telephone log, and mail log confirmed the program's practice and demonstrated all parties allowed to communicate with the youth are approved by the director of case management. During the annual compliance review, observations confirmed youth mail is searched prior to being sent and incoming mail is searched in front of the youth. Five youth were interviewed, and each reported they are given the opportunity to communicate with family, including visitation, telephone, and mail.

5.23 Search and Inspection of Controlled Observation Room	**Satisfactory Compliance**
The program shall conduct youth searches and room inspections prior to placing a youth on Controlled Observation.	

The program does not utilize controlled observation; therefore, this indicator is rated as non-applicable.

5.24 Controlled Observation	**Non-Applicable**
Programs shall only place youth in Controlled Observation when non-physical interventions would not be effective.	

The program does not utilize controlled observation; therefore, this indicator is rated as non-applicable.

5.25 Controlled Observation Safety Checks Release Procedures	**Non-Applicable**
The program shall conduct safety checks for youth on Controlled Observation. The program director or designee shall approve a release when it is determined, based on his or her behavior, the youth is no longer an imminent threat to self or others.	

The program does not utilize controlled observation; therefore, this indicator is rated as non-applicable.

5.26 Safety Planning Process for Youth	**Failed Compliance**
A residential program shall conduct an on-going safety planning process for each youth. The safety plan shall be designed to identify stimuli which have both positive and negative effects on the youth.	

The program implemented a process to complete safety plans for youth upon admission to the program. Four of the five safety plans were completed within fourteen days of admission, one plan was seven days late. The Safety Plan form utilized by the program incorporates trauma response principles; however, the form does not include required information on the youth's baseline behaviors, crisis recognition, and debriefing preferences. None of the plans were created jointly with the parent/guardian and did not include any collateral information or recommendations from current and formal assessments; instead the plans were created based on youth self-report. Documentation was provided indicating each of the youth's safety plans were reviewed with the youth every thirty days; however, none of the plans were updated. The program reported they had not updated any youth's safety plan during the annual compliance review period. The plans are maintained in an area accessible to staff; however, the program does not have a process in place to have staff review the plans. Five staff interviews were conducted and four did not know what the process was for reviewing safety plans. One staff reported the plans are easily accessible and staff can periodically review them. Five youth interviews were conducted. Two reported being involved in the safety planning process while the other three did not know what the safety plans were.