STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Alachua Academy

Sequel TSI of Florida, LLC
(Contract Provider)
3430 NE 39th Ave
Gainesville, Florida 32609

Review Date(s): November 5-8, 2019

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:

Gwen Nelson, Office of Program Accountability, Lead Reviewer (Standard 1)
Kelly Baldwin, Circuit 8, Probation, JPO Supervisor (Standard 2)
Jennifer Schad, Office of Program Accountability, Regional Monitor (Standard 3)
Katina Horner, Office of Program Accountability, Regional Monitor (Standard 4)
Forrest Hallam, Marion Regional Detention Center, Superintendent (Standard 5)
Dollie Wygant, Circuit 8, Probation, JPO Supervisor (Standard 2 and Interviews-Youth/Staff)

Program Name: Alachua Youth Academy
Provider Name: Sequel of Florida, LLC
Location: Alachua County / Circuit 8
Review Date(s): November 5-8, 2019

MQI Program Code: 1165
Contract Number: 10189
Number of Beds: 28
Lead Reviewer Code: 130

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
2.05 Gang Identification: Notification of Law Enforcement	
2.09 Performance Plan Development, Goals and Transmittal *	
2.11 Performance Summaries and Transmittals	
5.18 Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	
5.26 Safety Planning Process for Youth	

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	Satisfactory
1.07	Pre-Service/Certification Requirements *	Satisfactory
1.08	In-Service Training	Satisfactory
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)*	Satisfactory
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	Limited
2.06	Gang Identification: Prevention and Intervention Activities	Satisfactory
2.07	Residential Assessment for Youth (RAY)	Satisfactory
2.08	Youth Needs Assessment Summary (YNAS)	Satisfactory
2.09	Performance Plan Development, Goals and Transmittal *	Limited
2.10	Performance Plan Revisions	Satisfactory
2.11	Performance Summaries and Transmittals	Limited
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 *	Non-Applicable
3.03	Non-Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory
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 *	Satisfactory
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 *	Satisfactory

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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	Satisfactory
4.16	Medication/Sharps Inventory and Storage Process	Satisfactory
4.17	Infection Control/Exposure Control	Satisfactory
4.18	Prenatal Care/Education	Satisfactory

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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 *	Satisfactory
5.05	Census, Counts, and Tracking	Satisfactory
5.06	Logbook Entries and Shift Report Review	Satisfactory
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	Satisfactory
5.17	Disaster and Continuity of Operations Planning (COOP)	Satisfactory
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Limited
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 *	Non-Applicable
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	Limited

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Program Overview

Alachua Academy is a twenty-eight-bed program, for twelve to eighteen-year-old females located in Gainesville, Florida. The program is operated by Sequel of Florida, LLC, through a contract with the Department. The program provides Substance Abuse Overlay Services (SAOS). In addition, the program fosters youth by providing delinquency interventions including Living in Balance (LIB), Impact of Crime (IOC), and VOICES. Additional, treatment services provided includes individual, group, and/or family therapy seven days a week. The program also provides recreational therapy. The program's administration is comprised of a facility administrator, assistant facility administrator, clinical director, director of nursing, lead teacher, and physical plant manager. Case management services are provided by two case managers and a transition specialist. The mental health staff at the program includes the director of clinical services who is a licensed mental health counselor, two full time therapists, and one part-time therapist. Medical services are offered from 7:00 a.m. to 7:00 p.m., seven days a week, and are provided by a contracted medical doctor (MD) who also serves as the designated health authority (DHA). The DHA has a specialty in family medicine. Educational services are provided by the contract provider. The layout of the program includes the main building, separate building used for education and training classes, and a utilities and storage building. The program has sixteen operating security cameras providing coverage. At the time of the annual compliance review, the program had three direct care worker vacant positions.

Strengths and Innovative Approaches

- The program has a partnership with the local Toastmasters organization to provide on-site mentorship, public speaking, communication, and leadership training for the youth.

- Alcoholics Anonymous and Narcotics Anonymous meetings are provided on-site for youth.

- The program has a contract with the Down Dog Yoga to provide on-site yoga classes bi-weekly for the youth.

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 for conducting initial background screenings of all new employees, interns, volunteers, and mentors. Nineteen staff were hired since the last annual compliance review and all had a background screening completed prior to their start date. Twelve of the new hires were direct care staff eligible for a pre-employment assessment tool. All twelve direct care staff completed the pre-employment assessment tool and received a passing score. The program reviewed each staff's criminal history report, the Central Communications Center person involvement report, Staff Verification System, and the Florida Department of Law Enforcement's background screening. The Annual Affidavit of Compliance with Level 2 Screening Standards was completed and sent to the Department's Background Screening Unit on December 26, 2018, as required. The program did not have any contracted staff, volunteers, or mentors requiring initial background screening during the annual compliance review period.

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 to conduct five-year rescreening of employees, contracted staff, volunteers, and mentors. The program did not have any employees, contracted staff, volunteers, or mentors eligible for a five-year rescreening during the annual compliance review period.

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 in place to ensure the provision of an abuse-free environment. Based on formal and informal interviews with staff, the code of conduct clearly communicates the expectations for ethical and professional behavior when staff interact with youth promoting emotional and physical safety and incorporating trauma responsive practices. The program complies and support the Department's policy on abuse reporting, allegations of child abuse or suspected child abuse reported to the Florida Abuse Hotline and the Department's Central Communications Center (CCC) within two hours of all reportable incidents. The staff are trained on the policy and procedures of reporting abuse calls. The program's abuse policy states the unhindered access for youth and staff to make the decision to report allegations of abuse. Youth are given immediate access when requesting to make an abuse call. The youth goes to the staff and request to use the telephone, staff will dial the number, and give the telephone to the youth to speak to the operator. The staff member will speak to the operator to obtain the operator identification number and incident number, if assigned at the end of the youth's call. Since the last annual review, the program had a total of three calls to the abuse hotline. None of the three calls were substantiated. Five interviewed youth indicated they felt safe in the program. The youth stated they have never been denied a call to the Florida Abuse Hotline or CCC. Two of the five youth stated hearing staff use profanity occasionally among conversations between staff. The facility administrator's (FA) interview indicated, the FA has clear understanding of the policy and procedures relating to an abuse-free environment.

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 has a policy and procedures for responding to allegations of physical, psychological, or emotional abuse by staff and youth. The program substantiated one incident relating to violation of policy/rule by three staff members during a medical transport. Two staff members received written reprimands and one staff received verbal coaching.

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 has a policy and procedures for reporting incidents to the Central Communications Center (CCC). The program experienced a decrease in the number of reportable incidents to the CCC. The program reported eleven incidents to the CCC in the last six months. All calls were reported to the CCC within two hours or within two hours of program staff becoming aware of the reportable incident. Nine of the eleven CCC reports were documented in the program logbooks. The remaining two incidents reviewed were staff related such as staff arrest. There were no internal incidents or grievances which should have been reported to the CCC. The facility administrator's interview indicated the steps taken if a reportable incident occurs which includes contacting the Florida Abuse Hotline as well as the CCC and if warranted, the police department. All notifications will be made within the required time frame. If the incident is Prison Rape Elimination Act (PREA) related, the PREA policy will be implemented.

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 policy and procedures for the use of physical intervention techniques in accordance with Florida Administrative Code. The program's Protective Action Response (PAR) plan has been approved by the Department. The program has not experienced an increase in the number of PARs since the last annual compliance review. The program's PAR rate during the annual compliance review period was 10.56, which is above the statewide Residential PAR rate of 2.35. There were twenty-four PAR incidents in the past six months. Five of the twenty-four incidents were reviewed. The five reviewed reports were completed by the end of the staff member's workday and included statements from all staff involved. One of the reviewed five reports documented injuries to the youth and staff. None of the reports indicated the youth alleged abuse. The five reports were reviewed by a PAR certified instructor or supervisory staff. A post-PAR interview was completed with each youth. The five reports were maintained in a binder. The facility administrator's interview indicated, PAR reports are completed and reviewed utilizing closed circuit television (CCTV) if available to confirm staff properly utilized techniques

according to policy. If a staff is found using excessive or unnecessary force, the staff is removed from youth contact pending an internal investigation. The incident is reported to the Central Communications Center (CCC), if warranted.

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 policy and procedures in place for pre-service training requirements for new staff during the initial 180 days of employment. The program submitted in writing, a list of pre-service trainings to the Department's Office of Staff Development and Training including course names, descriptions, objectives, and training hours for all instructor-led training. The training plan was approved on February 7, 2019. Five staff training records were reviewed. Each of the staff were certified within 180 days of hire and completed more than the required 120 hours of pre-service training. All five records included documentation of the required trainings including professionalism and ethics, Protective Action Response (PAR), suicide prevention, emergency procedures, cardiopulmonary resuscitation (CPR), first aid, use of an automated external defibrillator (AED), child abuse reporting, and Prison Rape Elimination Act (PREA). All instructors providing training were qualified to do so. Trainings were documented in the Department's Learning Management System (SkillPro).

1.08 In-Service Training	Satisfactory 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 a policy and procedures in place for annual in-service training requirements for staff. A review of five staff training records for twenty-four hours of in-service training as specified in the Florida Administrative Code revealed training was completed as required. The program's in-service training calendar for 2018 and 2019 have the schedule of trainings with sign in sheets, agendas, and other documentation to support the training was delivered. One of the five training records reviewed was a supervisor. The supervisor's records indicated eight hours of management training. The program submitted in writing, a list of in-service training to the Office of Staff Development and Training including course names, descriptions, objectives, and training hours for instructor-led training on February 7, 2019.

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 including training requirements to address the program's grievance process. The program's grievance process includes informal, formal, and

appeal phases. The informal phase is accomplished through a “Request to Talk” form which is checked each shift by supervisors. If the grievance is not resolved during the informal phase, the youth submits a formal grievance. The supervisor has four days to review, investigate, and respond to the youth. If the youth is not satisfied with the response, the youth may appeal to both the assistant facility administrator (AFA) who has twenty-four hours to respond and the facility administrator (FA) who has forty-eight hours to respond. The program maintains copies of the grievances in a grievance binder for twelve months. In the past six months, there were twelve grievances recorded of which seven were reviewed. All seven grievances reviewed were resolved during the formal phase and within twenty-four hours of the youth filing the grievance. Five interviewed youth were able to explain the process for completing a grievance. Five staff were interviewed and each reported youth may request assistance in completing the grievance form. Additionally, four staff stated forms are placed throughout the program and a supervisor and the FA review the grievance. The facility administrator’s (FA) interview confirmed the process for grievances to include three phases and the time frames associated with each phase.

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 has a policy and procedures for delinquency interventions and facilitator training. According to the facility administrator’s (FA) interview, education and experience are the main considerations when determining which staff will deliver life skills trainings or groups. The FA interview indicated, youth are assigned to staff, case managers, and intervention groups according to their individualized needs and priorities. The program is providing structured, planned programming, or activities at least sixty percent of the youth’s awake hours. Staff members providing Impact of Crime (IOC), VOICES, and Living in Balance (LIB) received the required training to facilitate the group. A review of sign-in sheets confirmed groups were delivered, as required.

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 for youth to receive life and social skills training. The program provides groups Monday through Sunday. Five youth records were reviewed, and confirmed the youth are receiving services as outlined in their treatment and performance plans. Five youth were interviewed and indicated they participate in life skills training which includes VOICES. The youth also indicated they have learned coping skills through participation in the groups to include thought stopping and relapse prevention. A review of sign-in sheets confirmed VOICES were delivered, as required.

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 has a policy and procedures in place to ensure the youth receive restorative justice awareness. The program uses the Impact of Crime (IOC) curriculum. This curriculum assists youth in accepting responsibility for harm they have caused by their past criminal actions and challenges them to modify their irresponsible thinking. The curriculum teaches youth about the impact of crime on victims, their families and their communities, and exposes youth to the victim's perspectives. The youth participate in restitution activities and community service projects. The youth make blankets and donate the blankets to the homeless shelters, participate in community service activities at "Bread of the Mighty" food bank at least once a month, and donates Easter baskets to the local church. Case managers facilitate IOC groups. The case managers completed the required training and are certified to facilitate IOC groups. A review of the IOC curriculum, sign-in sheets, agendas, and other supportive documents indicated IOC groups are being conducted as designed. Five youth records were reviewed, documentation supported the youth received services to increase their accountability for criminal actions and harm to others. The facility administrator's interview indicated, youth participate in IOC groups on Tuesdays and Thursdays.

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 provides gender-specific programming using the VOICES curriculum. The program director explained the program addresses the needs of their target population through VOICES, which is a program of self-discovery and empowerment for girls and is based on the realities of the girls' lives and the principles of gender responsivity. VOICES groups are conducted weekly as supported by a review of the group sign-in sheets.

1.14 Internal Alerts System and Alerts (JJIS) (Critical)	Satisfactory 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 to determine how alerts are identified, documented, updated, and communicated to staff. The facility administrator's interview indicated alerts are reviewed by management and direct care staff daily. The program has an internal alert log

where the youth pictures are posted with a color-coded system to identify various alerts. The program has an alert log which is updated as needed and posted in master control and in the kitchen. Alerts are documented in the logbook if an incident occurs on a shift. The manager for each respective department is responsible for ensuring alerts for youth are updated and entered into the Department's Juvenile Justice Information System (JJIS). Youth with previous alerts for suicide risk entered into JJIS reflected the alert was updated and removed as required by the clinical director. A comparison of internal alerts and alerts in JJIS indicated there were no inconsistencies.

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 an official case record labeled "Confidential" for each youth. The program separates the youth record into an individual management record, health care record, and mental health/substance abuse record. The individual management record is labeled with the youth's name, Department identification number, date of birth, county of residence, and committing offense. The individual management record contains legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous. Youth records are stored in a locked room.

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

The program has a policy and procedures to promote constructive input by youth through the development of a youth advisory board and townhall meetings. A review of the youth advisory board and townhall meetings sign-in sheets and agendas confirmed meetings are being held. Five youth were interviewed on providing input into the program. All five youth indicated they use "Speak Out" forms, the advisory board, and townhall meetings to voice concerns. The facility administrator's (FA) interview indicated, youth complete monthly surveys and exit surveys to make recommendations for resolution to improve conditions and enhance the quality of life for staff and youth in the program. The FA interview also indicated, community meetings and townhall meetings are conducted to provide youth a forum to voice their concerns, issues, and program feedback monthly or as special needs arise.

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 has a policy and procedures for a community advisory board. The facility administrator's interview indicated, the community advisory board consists of members from local law enforcement, victim advocacy, and religious community. Member invitations were submitted to judicial officials and the Department's education liaison for membership. Meetings are held quarterly at the convenience of the members, and members are encouraged to participate by telephone if unable to attend in person. A review of attendance rosters and sign-sheets indicated law enforcement, community partners, school board, faith community, victim

advocate, and a parent/guardian whose child was recently released from the program attend quarterly meetings. The program director provided documentation of efforts to solicit and keep members actively involved Advisory board meetings were held on March 6, 2019, May 30, 2019, and September 12, 2019. Topics on the agenda included a review of family day, community service ideas, and program needs.

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

The facility administrator's (FA) interview indicated, all staff meetings are held once a month and on an as-needed basis, and supervisors are informally updated of any development changes. The program has employee of the month and weekly staff appreciation events to improve staff morale. The FA interview indicated how data is used for program planning including the use of youth and parent surveys and employee satisfaction surveys. Additionally, the FA indicated, relevant information such as published reports are discussed during monthly staff meetings. Five staff were interviewed and each stated staff meetings are held monthly. Staff reported topics discussed includes the behavior management system, day-to-day operations, upcoming trainings, attendance, use of cell phone while on duty, policies, and dress code. The five staff confirmed they are briefed on reports, annual compliance reports, and youth and parent surveys. A review of sign-in sheets and agendas support monthly staff meetings are conducted.

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 for staff performance and evaluations. The policy states staff will be evaluated after their initial ninety-day probationary period and annually, thereafter. A review of five personnel records contained copies of job descriptions which identified the staff member's performance standards. A review of five performance evaluations revealed the evaluations were completed as required. The performance standards matched the job descriptions for each staff. The evaluation form includes a section for those staff members who facilitate an evidenced based group. Three of the five interviewed staff members reported receiving a ninety-day performance evaluation and a performance evaluation annually. Two of the five interviewed staff reported receiving evaluations every six months. The staff stated management utilize coaching notes throughout the year.

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

The program has a written policy and procedures for recreation and leisure opportunities for youth. The program employs a recreation therapist as required by their contract. The program's daily schedule indicated time for daily large muscle activity. The program has a separate recreation therapy schedule for recreation time which includes basketball, yoga, dance, dodgeball, incentives, and awards. The youth are allowed leisure time to engage in their chosen leisure activities such as letter writing, reading, church, and board games. Several incentive events are held to reward youth who achieved good grades in school and good behavior in the program. All recreation and leisure activities are geared toward helping youth to develop social and cognitive skills, nurturing teamwork and communication. Five interviewed youth indicated,

they receive varied opportunities throughout the day for mental and physical exertion for at least an hour each day. Five staff were interviewed and each confirmed the youth receive recreation each day and are offered a variety of opportunities

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 to notify the youth's parent/guardian by telephone within twenty-four hours of admission and written notification within forty-eight hours of admission. Additionally, written notification to the committing judge, juvenile probation officer (JPO), and post-residential counselor (if applicable) within five working days of admission. All five youth case management records (IHCRs) indicated the parent/guardian were notified by telephone during the intake process and written notification within forty-eight hours of intake. All five IHCRs indicated the judge, JPO, and post-residential counselor (if applicable) were notified as required.

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 to provide each youth with an orientation to the program, including rules, expectations, goals, and services applicable to the youth on the day of the youth's admission to the program. The program has an orientation checklist to ensure each youth is provided with this information as well a resident handbook which is provided to each youth along with a schedule. All five reviewed youth case management records indicated the youth received an orientation on the day of admission. Each youth signed indicating they received all materials. Five interviewed youth reported they received an orientation on the day of their arrival. The youth were able to describe the orientation process.

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 to obtain written consent of any youth eighteen years of age or older before discussing with the parent/guardian any information related to the youth's physical or mental health screening, assessment, or treatment. Two of the youth case management records reviewed were applicable for youth eighteen years of age or older. Both records included a consent form signed by the youth.

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 for classification of each youth at admission to determine the most appropriate group placement, sleeping arrangements, and to increase staff awareness of classification issues. The program reviews factors such as physical characteristics, stature, maturity level, special needs, history of violence, criminal behavior, sexual aggression or vulnerability to victimization, medical, suicide, escape and security risk, substance abuse history, and gang affiliation. Throughout the youth's stay, the program reassesses the youth's classification to increase the youth's privileges or freedom of movement, participation in work projects, or other activities involving tools or instruments possibly used as potential weapons or means of escape and participation in any off-campus activities. A continually updated internal alert system is used and is easily accessible to program staff. A review of five youth case management records indicated an initial classification of each youth was reviewed before they were assigned to a sleeping room. Reassessments were completed for each youth to increase privileges.

2.05 Gang Identification: Notification of Law Enforcement	Limited 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 to participate in the sharing of information with the Department of Juvenile Justice and local law enforcement and indicates the program must notify local law enforcement as well as the youth's juvenile probation officer (JPO) regarding gang information. Three youth case management records reviewed were applicable for youth with suspected gang involvement. There was no documentation in the three records where local law enforcement was notified of suspected gang activity. All three youth case management records indicated the youth's JPO was notified of gang activity. Two of the three case management records reviewed were applicable for the youth's home county being notified of gang activity and both records indicated letters were sent to law enforcement in those counties.

2.06 Gang Identification: Prevention and Intervention Activities	Satisfactory 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 to provide gang prevention strategies to all youth. The program utilizes pamphlets, discussions, and groups to provide gang prevention/awareness to all youth in the program. Three youth identified as having gang affiliation or membership participated in

gang prevention/awareness activities. All three reviewed youth case management records indicated relevant goals and objectives relating to gang intervention strategies were included in the youth's performance plan. Two of the gang related performance plan goals were listed on a different plan and form than the original and had another program of the same provider listed on the top of the performance plan.

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 to ensure an initial Residential Assessment for Youth (RAY) assessment of each youth is completed within thirty days of the youth's admission. The program must maintain the assessments in the Juvenile Justice Information System (JJIS). The policy indicates reassessments must be completed every ninety-days after the initial assessment. Five youth case management records were reviewed and all had assessments completed within the first thirty days of admission. The assessments were maintained in JJIS. Two of the youth case management records were applicable for a RAY reassessment. Two reassessments were not completed within ninety-days after the completion of the initial RAY and the records were subsequently not maintained in JJIS.

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 to ensure a Youth Needs Assessment Summary (YNAS) of each youth is completed within thirty days of admission and the assessments are maintained in the Juvenile Justice Information System (JJIS). Five youth case management records were reviewed and each youth had assessments completed within the first thirty days of admission. The assessments were maintained in JJIS.

2.09 Performance Plan Development, Goals and Transmittal (Critical)	Limited 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 requiring the intervention and treatment team including the youth to meet and develop a performance plan. The plan should include goals which are measurable, individualized, prioritized, and can be achieved by the youth prior to release. The performance plan is to be created and signed within thirty days of admission to the program. Five youth case manager records were reviewed and found two of the five youth records included performance plans created within the first thirty days. Three youth case management records had performance plans created eighty-two, eighty-five, and one hundred and thirty-eight days late. All five performance plans were created after the initial assessment. In all five youth case management records the treatment team leader, youth, administrative and living unit representatives, treatment staff, and educational staff were included in development of the plan and all signed the plan. One youth case management record was applicable for inclusion of the Department of Children and Families (DCF) caseworker in development of the performance plan' however, the case record did not include documentation of the caseworker being involved. Three of the five youth case management records included a performance plan with individualized goals based upon the prioritized needs including the top three criminogenic needs addressed. Two of the five youth case management records did not include the top three criminogenic needs addressed and a reason was not provided. One youth case management record did not target the youth's court-ordered sanctions. Each of the youth goals included targeted time frames for completion and responsibilities for youth, and four of the five included responsibilities for staff. One of the reviewed five youth case management records indicated the performance plan was not forwarded to the court within ten working days of completion. Five youth were interviewed and all five were able to explain the program's process for developing the performance plan and goals they were currently working on. One youth reported they did not have a copy of their performance plan.

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 to revise performance plans when determined necessary by the treatment team based on the Residential Assessment of Youth (RAY) reassessment, the youth's progress or lack of progress toward completing their goals, or newly acquired information. A review of five youth case management records did not warrant a plan revision.

2.11 Performance Summaries and Transmittals	Limited 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 to complete performance plan summaries every ninety-days after the completion of the initial performance plans or shorter intervals if requested by the committing court. The treatment team shall prepare a performance summary prior to the youth's release, discharge, or transfer from the program. The program shall disseminate the performance summary prior to the youth's release or transfer from the program within ten working days of the plan being signed. A review of five youth case management records found four of the five youth case management records reviewed were applicable for performance summaries. Three of the four youth records indicated the performance summary was completed within ninety-days of completion of the performance plan; however, two of the performance plans were created very late in the youth's stay at the program. One of the five youth records indicated the youth's performance summary was created on the same day as the performance plan and then subsequently deleted from the Juvenile Justice Information System (JJIS). The original performance plan for the one youth record was one hundred and thirty-eight days late. Four of the applicable youth case management records had summaries which included the youth's status on each goal, overall treatment progress, academic status, level of motivation, and overall behavior. One record did not summarize the youth's treatment progress, behavior, staff and peer interaction, or significant events. In four of the youth records, the youth could read and add comments and was provided a copy of the summary. All four summaries were signed and dated by the treatment team leader, facility administrator or designee, and youth. A copy of each summary was sent within ten working days to the committing court, juvenile probation officer (JPO), youth, and parent/guardian in three of the four youth records. In one record, a copy of the summary was not provided to the Department of Children and Families (DCF) case worker. Three of the five youth case management records reviewed were applicable for a release summary being completed and sent to the JPO. All three summaries were sent to the JPO as required; however, none of the three were sent at least forty-five days prior to the youth's release. The Pre-Release Notifications (PRN) and summaries were sent to the JPO seven, seventeen, and twenty-three days late. Two of the three summaries were retained in the youth's case management record and one had not been received back from the court. None of the youth case management records reviewed were applicable for the PRN being denied or for Sexually Violent Predator Program (SVPP) eligible youth. One of the four applicable youth case management records did not have record of the transition plan being sent to the JPO. All applicable interviewed youth reported they received a copy of their performance summary.

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 indicating the program shall to the extent possible encourage and facilitate involvement of the youth's parent/guardian in the case management process. The program remains in communication with the youth's parent/guardian at admission and throughout the duration of the youth's stay in the program. The parent/guardian is invited to all treatment team, exit, and transition meetings. If the parent/guardian is unable to attend, the program contacts them by telephone for participation. The program also participates in family days allowing the family members to visit the program and youth. Five reviewed youth case management records indicated from case notes, the parent/guardians participated in case management services. Two treatment team meetings were observed and the parent/guardian or Department of Children and Families guardian participated in each by telephone. Five youth were interviewed and all five responded their parent/guardians are involved in their case management.

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 regarding members of the treatment team. The team shall include at a minimum the youth, program administrator or designee, case manager, living unit and education representatives, and other responsible for providing or overseeing the provision of intervention and treatment services. The facility administrator or designee is responsible for identifying a leader for the treatment team to oversee the team's efforts in effective management of each case. In five youth case management records reviewed, the treatment team included the treatment team leader, youth, administrative and living unit representative, treatment staff, education staff, Department of Children Families case worker (if applicable), juvenile probation officer (JPO), parent/guardian, transition service manager, and nurse. The youth's parent/guardian and JPO were invited to attend in all five youth case management records reviewed.

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 requiring the youth's performance plan to incorporate the youth's treatment or care plan. When a youth has a current behavior support plan or case plan through the Agency for Persons with Disabilities (APD), the program shall coordinate the youth's performance plan with the youth's APD plan for related issues. A youth's performance plan should incorporate their academic progress monitoring plan. Five youth case management records were reviewed. All five records indicated the performance plan included the youth's academic performance and safety plans. In one of the five youth case management records, the youth's separate treatment plan for substance abuse and mental health counseling was not referenced in the performance plan. One case record was applicable for a current case plan

through the Department of Children and Families (DCF) and the program coordinated the performance plan with the youth's case plan by incorporating family counseling.

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 to ensure the interventions and treatment team meets every thirty days (formally and informally) to review each youth's performance. The meetings should include the youth's progress on performance plan goals, Residential Assessment on Youth (RAY) reassessment results, positive and negative behavior including behavior resulting in physical response/intervention. Five youth case management records were reviewed and each indicated treatment team meetings were held bi-weekly, both formal and informal. The formal and informal performance plan reviews were documented in the youth record and included the youth's name, date of review, comments from treatment team members, synopses of the youth's progress, progress on performance plan goals, positive and negative behaviors, and treatment progress. One of the five youth case management records reviewed, the youth's substance abuse and mental health treatment progress was not recorded in the review. All five youth were provided the opportunity to demonstrate skills the youth learned in the program. None of the records reviewed were applicable for physical interventions. Five youth interviews were reviewed and all five indicated they were provided the opportunity to demonstrate skills the youth learned in the program. All five youth indicated staff review their performance including progress on performance plan goals, positive and negative behavior, and treatment progress.

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

The program provides appropriate career education based on age, length of stay, and is appropriate for the educational abilities of the youth in the program. Two open and one closed youth case management record were reviewed for career education. Documentation included a completed employment application, sample résumé, appropriate documents essential to obtaining employment, and an appointment with Career Source. Three reviewed youth case managements records included documentation the youth's parent/guardians and juvenile probation officer (JPO) were aware of the vocational plan for the youth. The program is a Type 2 programming level. An interview with the lead teacher indicated, the program offers Edmentum curriculum and students can choose three different career paths in Information Technology, Health Services, and Hospitality and Tourism.

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.	

Sequel Youth and Family Services provides education on a 250-day calendar distributed over twelve months which includes a minimum of twenty-five hours of instruction, weekly. The youth

receive credits for the education and training received while at the program. Review of the logbooks and an interview with the lead teacher indicated, there is a minimal disruption of class. Four of five youth interviews indicated disruptions occur because of other youth in class.

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

One open and two closed youth case management records were reviewed for educational transition plan. Each record had an individual education transition plan developed based on youth's post release goals beginning at admission to include all key personnel related to transition activities, included responsibility requirements, and post release needs. All the youth records reviewed for employability as a transition goal included provisions for continuation of education and or employment, appropriate documents essential to obtaining employment, and documentation the youth's case manager and parent/guardian are aware of the plan.

The educational transition plans of the three closed youth case management records were reviewed. All three records included copies of job applications, résumé, and other pertinent paperwork needed to enroll in an educational, employment, and vocational setting. Each record contained the completed vocational certificates demonstrating skills the youth learned in the program. All three plans addressed services and interventions based on the youth's needs and post-release education plans, recommended educational placement for post release based on the individual needs of the youth. Each record contained a sample employment application, résumé indicating the youth's education, work, and skills. The juvenile probation officers and parent/guardians were notified of the plan, documents, and post-release discharge plans. Two of the three youth records did not contain a valid Florida identification card due to the families choosing not to send the required documentations to obtain a birth certificate, social security, and Florida identification card.

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.*	

Five youth case management records were reviewed to access documentation of the transition planning, conference, and Community Re-entry meetings. All records specified transition conferences within the required time frames. All parties were notified and requested to participate including the youth, parent/guardian, and treatment team leader. The transition plans

indicate the end dates for the youth's release, goals, the youth transition back into the community. The Community Re-Entry meetings were all conducted prior to the youth's release.

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.	

Three youth closed case management records were reviewed. All three records provided education records and certifications earned by each youth. The portfolios did not contain a State-issued identification card, social security card, or a birth certificate. The parent/guardians of the youth did not provide the required paperwork to the program. All youth records indicated the youth received a calendar outlining appointments and other relevant dates. The exit portfolio was not forwarded to the juvenile probation officer in two of the three records. One of the three records did not contain information pertaining to Career Source appointments.

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.	

Three youth case management records were reviewed for exit conference completion. All youth participated in an exit conference held within the required time frame. All three records specified participation in the exit conference scheduled and conducted within the required time frame. Each exit conference included and documented the youth, parent/guardian, treatment team leader, education representative, juvenile probation officer, and other pertinent parties. All records indicated the exit conference was conducted separate from the transition and Community Re-Entry Team meetings.

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 designated mental health clinician authority (DMHCA) position is currently being filled by the regional clinical director who is a licensed clinical social worker (LCSW). A licensed mental health counselor (LMHC) was hired as the new DMHCA and is still in training and has not provided services or supervision. Both the regional clinical director and DMHCA have clear and active licenses in the State of Florida which both licenses expire on March 31, 2021. The DMHCA is on-site at least forty hours per week, weekends as needed, and is on-call twenty-four hours a day, seven days a week. The DMHCA is responsible for coordinating and verifying the implementation of necessary and appropriate mental health and substance abuse services in the program. A copy of the license and position description was reviewed. An interview with the DMHCA indicated, they hire qualified clinicians who are dedicated to this population. The DMHCA provides open channels of communication with all administrative staff, therapists, case managers, and youth care workers. The DMHCA reviews clinical charts each week to ensure mental health and substance abuse services are delivered as prescribed.

3.02 Licensed Mental Health and Substance Abuse Clinical Staff (Critical)	Non-Applicable
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 does not have any other licensed clinical staff other than the designated mental health clinician authority; therefore, this indicator rates as non-applicable.

3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff	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 designated mental health clinician authority (DMHCA) assures the non-licensed clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience. The program has three non-licensed mental health clinical staff providing mental health and substance abuse services in accordance with the

current contract. Two of the non-licensed staff are full-time and one staff is pro re nata (PRN), working weekends as needed. One of the non-licensed clinical staff is a registered clinical social worker intern. The DMHCA, a licensed mental clinical social worker (LCSW) provides one hour per week of on-site face-to-face supervision with the three non-licensed mental health clinical staff. A review of documentation for the past six months indicated supervision was held each week, with one exception. The PRN staff conducted groups on a weekend and there was no documentation of clinical supervision for the PRN staff during this week. The weekly supervision is documented on a form similar to the Department's Direct Supervision form. The form includes all the required information of competency areas, discussion/focus areas, and specific clinical focus. Each of the three non-licensed mental health clinical staff hold the appropriate master's-level of education necessary and in accordance with the current contract. The program is licensed in accordance with Chapter 397, Florida Statutes to provide substance abuse services. The license is current, expiring in October 2020. All three mental health clinical staff received twenty hours of training in assessment of suicide risk (ASR).

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 regarding mental health and substance abuse admission screening. Five youth mental health and substance abuse (MHSA) records were reviewed. All five youth had a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) administered on the day of admission. One MAYSI-2 form stated the admission date of June 1, 2019 in error as the youth's admission date was August 1, 2019. Each MAYSI-2 screening was completed by trained staff and completed in the Juvenile Justice Information System (JJIS) on the same day. All five MHSA records had documentation for existing mental health and substance abuse information was reviewed from each commitment packet. All five MAYSI-2 assessments indicated a further assessment was required. It is the program's policy for all newly admitted youth to be referred for a comprehensive mental health substance abuse evaluation. All newly admitted youth are administered an Assessment of Suicide Risk (ASR) as part of the intake process. Documentation confirmed each youth had an ASR during intake. Each youth was placed on standard supervision because of the ASR. Additional screenings completed by the program at intake include the Substance Abuse Subtle Screening Inventory (SASSI-2), Beck's Depression Inventory (BDI), and Suicide Probability Scale (SPS). Three youth MHSA records had documentation of a clinical mental health and substance abuse screening was completed in addition to the MAYSI-2. None of the clinical screenings were completed by a licensed staff as required. The clinical screening was not required by the program's policy and the program is no longer completing the additional screening instrument. An interview with the facility administrator confirmed the screening procedures as outlined in the program's policy.

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 regarding mental health and substance abuse assessments and evaluations. Five youth mental health and substance abuse (MHSA) records were reviewed. Each youth was referred for a new mental health evaluation on the day of admission. All five youth had a mental health evaluation completed within thirty calendar days of admission. All five evaluations were completed by a non-licensed mental health clinical staff and signed by a licensed mental health professional on the same date, within the required ten calendar days after the evaluation was conducted. The new evaluation included identifying information, reason for evaluation, relevant background information, behavioral observations, mental status examinations, interview or procedures administered, discussion of findings, diagnostic impression, and recommendations. Each evaluation also included a substance abuse assessment with patterns of alcohol and other drug abuse, impact of alcohol and other drug abuse on major life areas, and risk factors of continued alcohol and other drug abuse.

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 regarding mental health and substance abuse treatment. Five youth mental health and substance abuse records were reviewed. All five youth are assigned to a treatment team upon arrival to the program. The multidisciplinary team is comprised of the youth, program administration, direct care staff, education, medical staff, and mental health staff. Treatment team documentation validated it is comprised of representatives from mental health and substance abuse, case manager, direct care staff, medical, education, and psychiatrist, if applicable. A review of the five MHSA records confirmed all youth received individual, group, and family counseling by a licensed qualified professional or a non-licensed substance abuse substance abuse clinical staff working under the direct supervision of a qualified professional. All five youth receiving mental health treatment had an Authority for Treatment and Evaluation. All five youth had a signed Department Consent for Substance Abuse Treatment and Release of Substance Abuse Treatment Records. Treatment progress notes are documented on a form containing all the required information similar to Department Counseling/Therapy Progress Note. Group therapy is limited to ten or fewer youth for mental health groups and fifteen or fewer youth for substance abuse groups. All staff providing group counseling and/or therapy are qualified to provide services. Five youth were interviewed and all five youth confirmed they are participating in group therapy. Five staff were interviewed and all five confirmed direct care staff do not conduct mental health or substance abuse groups.

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 regarding mental health and substance abuse treatment and discharge planning. Five youth mental health and substance (MHSA) records were reviewed and all five had an initial treatment plan developed within one day of admission. The initial mental health and substance abuse plan is documented on a form containing all the required information similar to Department's Initial Mental Health/Substance Abuse Treatment Plan. The initial treatment plan was signed by the mental health clinical staff completing the form. All five of the initial treatment plans were completed by a non-licensed clinical staff and signed by the licensed mental health professional on the same date. The initial treatment plan was signed by all treatment team members who participated in the development of the plan.

All five individualized treatment plans were developed for each youth within thirty days of admission. The individualized treatment plan is developed on a form containing all the requirements similar to Department Individualized Mental Health/Substance Abuse Treatment Plan. Each individualized treatment plan was signed by the non-licensed mental health clinical staff completing the plan and signed by the licensed mental health professional on the same date. Each plan was signed by all treatment team members who participated in the development of the plan. There were documentation all five plans were mailed to the parent/guardian for signature; although, none of the plan were returned with a signature. One of the individualized plans included psychiatric services and was signed by the psychiatrist. Each youth had treatment plan reviews every thirty days following the development of the individualized treatment plan. The treatment plan review is developed on a form containing all the requirements similar to Department Individualized Mental Health/Substance Abuse Treatment Plan Review form. Progress notes determined youth received services as stipulated on the treatment plan with few exceptions. There was no documentation for four of the twenty-one possible individual and family therapy sessions for the five youth. There were nineteen dates without documentation of a possible 530 days for the five youth group sessions.

Three closed youth MHSA records were reviewed for discharge plans. All three had a discharge plan documented on Department Mental Health/Substance Abuse Treatment Discharge Summary. None of the youth were at suicide risk upon release. Each discharge plan included a recommendation of follow-up services for daily maintenance. Each discharge plan had documentation the plan was discussed with the youth, parent/guardian, and juvenile probation officer (JPO) at the transition and exit conferences. There was documentation a copy of the discharge plan was provided to the youth, parent/guardian, and JPO.

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 contracted to provide substance abuse overlay services (SAOS). The scope of SAOS treatment service delivery is outlined within the contract between the provider and the Department. The program provides urinalysis drug testing upon the youth's initial intake into the program. If a youth test positive, appropriate clinical intervention is provided. The program provides individual, group, and/or family therapy as part of each youth's treatment plan. Each youth is provided monthly individual and family sessions. Group therapy is provided daily. Group therapy interventions in the program includes Living in Balance and VOICES. Substance abuse groups offered do not exceed fifteen youth. Each youth receives daily therapeutic activities. A review of sign-in log reveals a psychiatrist is on-site bi-weekly to provide psychiatric evaluations, medication management, and participates in treatment planning for youth receiving psychotropic medications. Youth with co-occurring mental health disorders receive mental health treatment. The program is licensed under Chapter 397, which expires in October 2020. The program has non-licensed substance abuse clinical staff on-site seven days per week. Each therapist has a caseload of fourteen youth. A review of five youth mental health and substance abuse records confirmed, mental health services are being provided seven days per week.

3.09 Psychiatric Services (Critical)	Satisfactory 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 program has a contract with a psychiatrist to provide services on-site biweekly. Each youth admitted into the program receives an initial psychiatric evaluation within fourteen days of admission. Five youth mental health and substance abuse (MHSA) records were reviewed for psychiatric services. All five youth received an initial psychiatric evaluation within fourteen days of admission, regardless of their medication status. One youth was on psychotropic medication. Two additional youth MHSA records were requested and reviewed. Two of the three youth entered the program on psychotropic medication. One youth was prescribed psychotropic medication after their admission. The initial diagnostic psychiatric interview included medical history, mental health history, substance abuse history, mental status examination, DSM-IV, documented diagnosis, treatment recommendations, prescribed medications, explanation of the need for psychotropic medication, and frequency of medication monitoring. The evaluation was clearly identified as an initial diagnostic psychiatric interview. Page 3 of the Clinical Psychotropic Progress Note (CPPN) was completed for each youth. There was documentation the youth had been seen for a medication review by the psychiatrist at a minimum, every thirty days, for the three youth on psychotropic medication.

The psychiatrist is available for emergency consultation twenty-four hours a day, seven days per week. The psychiatrist meets with members of the treatment team face-to-face biweekly to discuss each youth scheduled for treatment team. The psychiatrist's recommendations for the youth are incorporated into the youth's individualized treatment plan. A review of documentation

for the past six months confirmed the psychiatrist is on-site biweekly, with no exceptions. The psychiatrist with specialized training in child and adolescent psychiatry, has a clear and active license to practice in the State of Florida expiring in January 2020. The psychiatrist has ultimate responsibility for the prescription and monitoring of psychotropic medications in the program. The psychiatrist actively participates in, manages, and supervises psychotropic medication services in the program. The psychiatrist's duties and responsibilities are not delegated. An interview with the psychiatrist confirmed their role in the coordination and implementation of psychiatric services in the program is to evaluate youth, coordinate care, and manage medication.

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 policy and procedures regarding suicide prevention services to include a written plan detailing suicide prevention procedure. The plan includes identification and assessment of youth at risk of suicide, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and a review process which includes suicide attempts and a mortality review. The plan also includes staff training of six hours annually. The plan is reviewed annually and was last reviewed on August 6, 2019 by the designated mental health clinician authority and the facility administrator.

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 policy and procedures to complete an Assessment of Suicide Risk (ASR) for each youth being admitted to the program. Five youth mental health and substance abuse (MHSA) records were reviewed. All five youth had an ASR at intake and as a result, were placed on standard supervision. Three additional MHSA records were requested and reviewed. All three youth had an ASR conducted based on statements made by the youth concerning suicidal ideation. All three youth were placed on precautionary observation (PO) as soon as staff determined the youth were at risk for suicide. All three youth had an ASR conducted on the same date on the Department's required ASR form. Two youth were placed on constant supervision and one youth was placed on one-to-one supervision. The two youth on constant supervision were Baker Acted. Upon the youth's return to the program, the youth were placed on one-to-one supervision. For each youth, PO was authorized and mental health staff provided supportive services. A follow-up ASR were completed prior to the removal of the youth from PO. For each youth, there was a conference held with the licensed mental health professional and the facility administrator (FA) to reduce the level of supervision. Discontinuation of close

supervision is in accordance with the program's suicide prevention plan. There was documentation the program notified the juvenile probation officer and parent/guardian of a youth's potential suicide risk, as indicated by the ASRs. Each of the ASRs were completed by non-licensed clinical staff under the supervision of a licensed mental health professional. Each of the ASRs were reviewed and signed by a licensed mental health professional on the same date. Each youth had an alert entered into the Juvenile Justice Information System (JJIS). Two of the youth's alerts remained open until the youth were removed from close supervision to standard supervision. One youth's alert remained open for two months, until closed by detention services. PO allowed each of the youth to participate in select activities with other youth in designated safe housing or observation areas of the program. PO did not limit or restrict the youth's activities to an area. There is documentation in the program's logbook of the youth on PO and close supervision with some exceptions. The documentation was not consistent for shift to shift. One youth was listed on PO and close supervision for the same shift. The same youth was noted to be moved to standard supervision and then noted to be on close supervision for the next shift. One youth did not have documentation of when close supervision ended and the youth was placed on standard supervision. One youth was not noted on one shift as being on PO. The program had documentation of training at staff meetings conducted quarterly for logbook documentation of youth on suicide precautions. The program does not utilize secure observation.

The FA has an established review process for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide as part of the program's suicide prevention plan. The review includes circumstances surrounding the event, procedures relevant to the incident, all relevant training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations for any changes, if needed. The program has a suicide response kit located in master control and in the medical clinic. Five staff were interviewed and all five staff were able to indicate a suicide response kit is stored in master control. Four staff indicated a suicide response kit is also stored in the medical clinic. All five staff were able to describe what to do when a youth expresses suicidal thoughts.

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.	

The program has a policy and procedures in place regarding suicide precaution observation (PO) logs. Five youth mental health and substance abuse (MHSA) records were reviewed. All five youth had an Assessment of Suicide Risk (ASR) conducted at intake and as a result, were placed on standard supervision. Three additional MHSA records were requested and reviewed. All three youth had an ASR conducted based on statements made by the youth concerning suicidal ideation. All three youth were placed on precautionary observation (PO) as soon as staff determined the youth were at risk for suicide. The PO logs for all three youth were maintained for the duration the youth was on suicide precaution. The appropriate level of supervision and observations of the youth's behavior were documented in real time and did not exceed thirty-minute intervals. Any warning signs were documented on the PO log and mental health clinical staff were notified. Each PO log was reviewed and signed by a shift supervisor and by a mental health clinical staff. The PO logs documented safe housing requirements. Only one of the three youth placed on PO was still in the program. The youth was interviewed and

confirmed while on PO, staff were always with them and was not left alone. During sleeping time, the youth slept in the hallway where staff were positioned.

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.	

Five staff in-service training records were reviewed. All five staff had a minimum of six hours annually of suicide prevention and implementation of suicide precautions. The six hours included two hours in the Department's Learning Management System (SkillPro) and four hours of instructor-led or webinar training. The past three quarters were reviewed for mock suicide drills. A drill was conducted each quarter for each shift, for a total of fourteen mock suicide drills. The program has two shifts daily. The next all staff meeting after a mock drill included a review of the mock suicide drill. Thirteen of the fourteen mock suicide drills included the use of cardiopulmonary resuscitation (CPR) and nine of the fourteen drills included the use of the suicide response kit. Thirty-three staff members participated in a quarterly drill.

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 has a policy and procedures regarding mental health crisis intervention services which includes written crisis intervention procedures. The crisis intervention plan includes notification and alert system, means of referral, communication, supervision, documentation, and review. The plan is reviewed annually by the designated mental health clinician authority, last reviewed on August 6, 2019.

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 written crisis intervention plan which includes a process for implementation of a crisis assessment form. The program documents a crisis assessment on a form which contains all the information on the Department's Crisis Assessment form. The program's form includes demographics, the reason for crisis assessment, method of assessment, current

mental health status, degree of dangerousness youth presents to self or others, initial clinical impression, supervision recommendations, treatment recommendations, recommendations for follow-up or further evaluation, and notifications. The program did not have to complete a crisis assessment during the annual review period.

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 a policy and procedures regarding emergency mental health and substance abuse services which includes a written mental health and substance abuse plan. The emergency mental health and substance abuse services plan includes immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Baker Act, transport for emergency substance abuse assessment and treatment under Marchman Act, documentation, training, and review. The plan designates two local receiving facilities for emergency transports dependent upon the youth's age. The plan is reviewed annually by the designated mental health clinician authority and facility administrator, last reviewed on August 6, 2019.

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 had two youth Baker Acted during the review period. Each youth was determined to need emergency care after an Assessment of Suicide Risk (ASR) was conducted. Each youth was placed on constant suicide precautions. For each youth, a licensed mental health professional completed the Baker Act paperwork. Each youth was transported out of the program by local law enforcement. When each youth returned to the program, the youth was placed on constant supervision. Each youth had a mental health referral for a Mental Status Examination to be completed. Each youth had an ASR completed by a non-licensed staff under the direct supervision of a licensed mental health professional. Each youth was maintained on constant supervision until properly transitioned to close supervision. The youth's supervision level was not lowered until the mental health staff conferred with the designated mental health clinician authority and the facility administrator.

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 contracts with a medical doctor who holds a clear and active license in the State of Florida, which expires on January 31, 2020. The medical doctor serves as the designated health authority (DHA). The DHA's license is free of complaint or discipline and has a specialty in family medicine. The program does not utilize a physician assistant or an advanced practice registered nurse. The DHA is on-site weekly and is on call twenty-four hours a day, seven days per week. A review of the sign-in log confirmed the DHA was on-site each week for the past six months with no exceptions. If the DHA is on vacation, another licensed medical doctor will complete medical services in their absence. The DHA communicates with program staff regarding the medical needs of all youth and is available for consultation twenty-four hours a day, seven days per week. An interview with the DHA confirmed, the DHA performs Comprehensive Physical Assessments, periodic evaluations, sick call follow-up if needed, referrals, review off-site care visits, and develops policies and procedures.

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's facility operating procedures (FOPs) for all health-related services were signed by the designated health authority (DHA) and facility administrator (FA) on August 6, 2019.The nursing protocols were signed by the DHA and FA on November 14, 2019. The last annual review was completed on December 6, 2018. Upon their review, the nursing staff signed a cover sheet for all nursing protocols. All newly hired nursing staff receive a comprehensive clinical orientation to the Department's healthcare policies and procedures, provided by a registered nurse. The FOPs related to psychiatric services were signed by psychiatrist.

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.	

Five youth individual healthcare records (IHCRs) were reviewed for Authority for Evaluation and Treatment (AET). All five youth had a signed AET record in the IHCR with the word copy stamped on it. All parental notifications were record behind the AET in all five records. An interview with the nurse indicated, youth normally arrive with a signed AET. If a youth arrives without one, the parent/guardian would be notified and a signature would be obtained.

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.	

Five youth individual healthcare records (IHCRs) were reviewed for parental notification and consent. Four youth were applicable for parent/guardian notification for over-the-counter (OTC)

medication beyond those covered by the Authority for Evaluation and Treatment (AET). One youth required vaccinations not consented for on the AET and consent was provided. One youth was taken off-site for emergency care and two youth were taken off-site for routine medical treatment. Verbal notifications were witnessed and documented in the progress notes as well as written notification was sent for newly prescribed medication for four applicable youth. None of the youth were in the care of the Department of Children and Families (DCF). One youth required parental notification regarding psychotropic medication. Two additional IHCRs were reviewed for a total sample size of three. All three IHCRs documented initial verbal consent along with a written Clinical Psychotropic Progress Note (CPPN) sent to the parent/guardian. Verbal consents were witnessed and signed consent by the parent/guardian was documented in all three cases.

Five youth IHCRs were reviewed for vaccination verification. Verification of immunizations by a nurse were documented on the date of admission for all five youth. The program reviews the Florida Shots and utilizes the Immunization Tracking Record. One youth did not have the required immunizations and parental notification was documented for consent. None of the youth had a religious exemption from immunization. An interview with the nurse confirmed, the immunizations are reviewed on the date of admission.

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.	

Five youth individual healthcare records (IHCRs) were reviewed for healthcare admission screening. All five IHCRs contained a Facility Entry Physical Health Screening form (FEPHS) completed on the date of admission by an administrator or supervisor and reviewed by a registered nurse (RN) on the day of admission. None of the youth sampled had a change in physical custody. There was one instance and the youth's record was reviewed for the current population. The youth had a new FEPHS rescreening completed by an RN upon their return to the program, as required.

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 youth orientation to healthcare services/health education. All five IHCRs documented orientation of health care services upon admission. The program's policy for healthcare education and orientation forms includes access to medical care, how to access sick call, what constitutes an emergency and when to notify staff, medication process, the right to refuse care, what to do in the case of a sexual assault, and the non-disciplinary role of the healthcare providers. Each youth signed documents confirming the healthcare orientation. The list of healthcare contacts reviewed 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.	

Five youth individual healthcare records were reviewed for designated health authority (DHA) admission notification. Three youth were applicable for having a suspected chronic condition upon admission. None of the youth were identified as in need of emergency care. It is the program's practice to notify the DHA of all admissions. Notification to the DHA was documented in each youth's admission progress note.

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.	

Five youth individual healthcare records (IHCRs) were reviewed for health-related history (HRH). All five IHCRs documented the HRH was completed on the youth's date of admission by a registered nurse (RN). The designated health authority (DHA) signed all five HRHs and indicated a review was completed on the Comprehensive Physical Assessment (CPA) as well. All five IHCRs documented the HRH was completed before the completion of the CPA. An interview with the nurse confirmed the HRH is completed at the time of admission by a RN.

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 for completing the Comprehensive Physical Assessment (CPA) for youth. The program documents all youth physicals utilizing the Department's CPA form. All youth were admitted with a current physical; however, a new physical was completed by the designated health authority (DHA) for all five youth. The CPA is completed in accordance with Florida Administrative Code, 63M-2.0044 requirements. All sections of the CPAs were appropriately marked and completed within seven days of admission as required. Three youth did not complete the genital exam and each youth signed the CPA to document refusal. The Department's Problem List was updated for all five youth. The program has a policy and procedures for completing Tuberculosis Screening. All five youth individual healthcare records included verification of a documented Tuberculin Skin Test (TST) completed within the past year. A current TST was documented on the CPA and the Infectious and Communicable Disease (ICD) form for all five youth. None of the youth required chest x-rays because of the TST screening. An interview with the nurse confirmed each youth is administered a TST yearly.

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.	

Five youth individual healthcare records (IHCRs) were reviewed for sexually transmitted infection (STI) and human immunodeficiency virus (HIV) screening. All five youth were screened and evaluated for STIs. Each youth was referred to the designated health authority (DHA). No additional testing was ordered for any of the five youth. Each youth were recently tested at the

detention center and the results were documented on the Infectious and Communicable Disease (ICD) form. None were applicable for rescreens due to a change in custody.

Each youth provided HIV screening was offered testing. Four youth signed a consent form and agreed to HIV testing. A certified HIV counselor from the Alachua County Health Department conducted the testing for all four youth. Documentation of pre-test and post-test counseling was documented on the youth Health Education Record for three of the four youth. The HIV test results are maintained in the lab section of the IHCR in a sealed envelope marked “confidential” in accordance with Florida Statues 381.004. The HIV test results are prohibited from the program’s internal alert list. Four of five interviewed youth stated they can request an HIV test. The remaining youth stated they could not.

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.	

Five youth individual healthcare records were reviewed for the sick call process and all five were applicable. Sick call is provided twice a day, seven days a week by a registered nurse (RN). Twenty-seven sick call requests were reviewed. Youth were seen the same day or within twenty-four hours of the request. None of the youth presented with similar sick call complaints three or more times within a two-week period. The youth completed a Sick Call Request form, which is placed in a secured box inaccessible to other youth and retrieved by a nurse. The completed Sick Call Request forms were recorded in the progress note section of the IHCR in reverse chronological order. Sick call is conducted twice daily as required by the contract. The sick call forms documented vital signs, treatment education, and follow-up in accordance with Florida Administrative Code 63M-2. Twenty-six of the twenty-seven sick calls were documented on the Sick Call Index and Sick Call Referral Log. There were no sick calls during the week of the annual compliance review to observe.

Five youth were interviewed on how quickly a youth can be seen by a nurse once a sick call request is made. Two youth stated immediately and three stated within one day. Five of seven interviewed staff stated the nurse conducts sick call. Two staff stated a supervisor can conduct sick call as well.

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 regarding episodic and emergency care. Emergency medical and dental care including emergency medical services (EMS) are available twenty-four hours a day, seven days a week. Five youth individual healthcare records (IHCRs) were reviewed for episodic care. Two youth IHCRs were applicable, one additional IHCR was reviewed for a total sample of three. Five episodic care events were reviewed for three applicable youth and all were documented on the Episodic Care Log, as required. None of the episodic care events were completed by non-healthcare staff. On-site care by the nurse was documented with standard narrative charting which included the date/time of the episodic care, nature of the complaint, over-the-counter medications given, treatment provided, referral to off-

site care if needed, education/instruction to the youth if needed, and placed on the alert list if applicable.

The program has eight first aid kits located in the kitchen, mailroom, school office, both classrooms, and the multi-purpose room. There are two first aid kits stored in administration for the vehicles utilized to transport youth. The program has two suicide response kits located in master control and the remaining one in the medical clinic. Three first aid kits were opened and stocked with the contents listed in the policy and approved by the designated health authority (DHA). No expired contents were found. Documentation confirmed expiration dates of contents and the first aid kits are monitored weekly by a nurse and replenished as needed.

The program has one automated external defibrillator (AED) located in administration. The instruction guides are attached to the AED and a manual is stored next to the AED. There was documentation the AED is monitored weekly by a nurse. The AED batteries expire in December 2023 and were last changed in April 2019. The AED pads expire in December 2021 and were last changed in October 2019. A test of the AED was conducted by a nurse and found the AED worked properly.

Mock emergency medical drills are conducted at least quarterly on each shift. Mock emergency medical drills were reviewed for the past three quarters. Cardiopulmonary resuscitation (CPR) was demonstrated on each shift for each quarter. A list of emergency numbers is maintained in master control, medical, and both administrator's offices inaccessible to youth. All staff received training on the use of an epinephrine auto-injector on July 24, 2019. All licensed healthcare staff maintains current CPR and AED certification.

Five youth were interviewed and all five stated they can see a dentist or doctor if needed. Five staff were interviewed and all stated they are personally allowed to call 9-1-1 if a youth has a medical emergency. One staff stated they would first notify the nurse and then call 9-1-1.

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.	

Five youth individual healthcare records were reviewed for off-site care. One youth was applicable and there were no other instances available for review. The parent/guardian was notified as required. The Department's Summary of Off-Site Care Form was utilized and emergency room discharge documents were both recorded in the youth's IHCR. The designated health authority (DHA) reviewed and signed all off-site care findings, discharge instructions, and information. Follow up was documented in the doctor's notes and progress note section of the IHCR.

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.	

Five youth individual healthcare records (IHCRs) were reviewed for chronic conditions. Three youth were applicable. One youth was taking medication on an on-going basis. All three youth had a medical grade of two or higher. All three youth were placed on the chronic condition list.

Each youth had a periodic evaluation at least every three months with no lapses indicated. Each youth had a specialized treatment plan. Periodic evaluations are tracked using the Department's Chronic Physical Health Conditions Roster Form. Each youth had periodic evaluation documented in their IHCR recorded in the progress note section in reverse chronological order. The periodic evaluation is conducted prior to the renewal of prescription medication in one applicable case. The Department's Problem List was updated for each youth as required in accordance with Florida Administrative Code 63-M. An interview with the nurse confirmed, periodic evaluations are monitored using a medical tracker to ensure youth are seen at least every three months. An Interview with the facility administrator confirmed the understanding of this requirement as outlined in the program's facility operating procedures.

4.15 Medication Management	**Satisfactory 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.	

Five youth individual healthcare records (IHCRs) were reviewed for admission into the program with prescribed medication. One youth IHCR was applicable, two additional IHCRs were reviewed for a sample size of three. Medication was verified for all three youth prior to being admitted into the program. The prescriptions were verified in each youth's progress notes utilizing the Department's Prescription Medication Verification Checklist Form. The designated health authority (DHA) was contacted to obtain the order to resume the medication regimen for all three youth. All medications were current, had a valid order, and were given as prescribed. In all three cases the medication was continued and the DHA placed an order on the Practitioner Order Form. Over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET) form are administered according to approved protocols. The standard Department Medication Administration Record (MAR) is used to document all medication and treatment. The MAR clearly indicates medication start and stop dates. Staff initialed each administered medication entry. There were no lapses or errors in medication administration. The nursing staff documents side effects at a minimum weekly on the MAR. The six rights of medication administration are maintained. Refusals are clearly documented on the MAR and on a separate refusal form.

Medication administration was observed for five youth. Medication administration was completed by a registered nurse (RN) and a direct care staff was providing supervision for the duration of medication pass. The RN takes the cart to the dining room area where youth are seated. The medication cart was unlocked by the RN and none of the medication pass was not pre-poured. Youth are called one at a time and identified by name, a color photo is next to each youth's MAR, and the Six Rights to Medication Administration are verified. The youth was aware of the medication they were taking and the side effects of the medication. The RN observed each youth to ensure their medication was swallowed. The direct care staff observed the youth's mouth and had them cough. This routine was followed for all five youth observed.

All medications are stored in secured areas inaccessible to youth inside the medication cart and inside cabinets in the medical clinic. All non-controlled medications prescribed and OTC are stored separately type. Narcotics and controlled medications are stored behind two locks in a separate locked box inside the locked medication cart. There was currently one youth on-site prescribed a controlled medication. There were currently no youth prescribed medication requiring refrigeration. There is a secured refrigerator in the medical clinic utilized for medication only when necessary. Syringes and sharps are secured in a cabinet inaccessible to youth. The

medication cart was clean, organized, and separated by medication type. Stock medication was separated from medication prescribed to youth.

Five youth were interviewed and all five stated medication is given to them by the nurse. Five staff were interviewed and all five stated the nurse provides medication to the youth. Two staff stated a supervisor can provide medication as well.

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.	

Any medical equipment classified as sharps are securely stored and inventoried by using a routine perpetual inventory descending count as each sharp is utilized and disposed. All medications are identified and secured in a locked area designated for storage of medications. Different medication forms are separated. A perpetual daily running inventory of medication utilized for all sharps and over-the-counter (OTC) medications is maintained. All controlled substances have a perpetual inventory and are stored separately from other medications. Controlled medications are stored behind two locks in a separate locked box inside the locked medication cart. Shift-to-shift inventory counts are conducted on all controlled substances and documented on the youth's Individualized Controlled Medication Inventory Record with the number of dosages remaining after each administration documented on the same record. Random inventory counts were conducted with the nurse on one controlled medication, three sharps, three prescribed medications, and three OTC medications. All inventories were accurate. Inventories for medications and sharps for the past six months were accurate.

The program has a policy and procedures for the disposal and destruction of expired or discontinued medications. Non-controlled medications are destroyed in the presence of two registered nurses (RN). Controlled medications are destroyed with the pharmaceutical representative and two RNs.

Supervisory level non-healthcare staff trained in the delivery and oversight of medication self-administration may assist in the delivery of medications only when licensed staff are not on-site.

An interview with the nurse confirmed the procedures for maintaining medication and sharp inventories along with the disposal process.

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 for infection and exposure control signed by the facility administrator (FA) and designated health authority (DHA) on August 12, 2019. The program's infection control procedures includes prevention, containment, treatment, and reporting requirements related to infectious diseases according to Occupational Safety and

Health Administration (OSHA) federal regulations and the Center for Disease Control (CDC) guidelines. The infection control procedures includes common diseases of childhood, self-limiting episodic contagious illnesses, viral or bacterial infectious disease, tuberculosis, hepatitis, bloodborne pathogens, outbreaks or epidemics, lice or scabies, methicillin-resistant staphylococcus aureus (MRSA), foodborne illnesses, bio-terrorist agents, and chemical exposures in the workplace. Hepatitis B immunizations are available for staff upon hire. Staff have access to protective equipment. There are documentation standard universal precautions are followed by all staff. There were no instances in which local county health department, CDC, or Central Communications Center (CCC) should have been notified regarding an infectious disease. The policy includes a comprehensive process for needle stick post-exposure evaluation. There were no incidents where youth or staff experienced a facility occupational exposure. The program has an exposure control plan written in accordance with OSHA standards reviewed and signed by the facility administrator (FA) and designated health authority (DHA) on August 12, 2019. The exposure control plan is available to all staff. The exposure control plan included risk of assessment and methods of compliance. There were no instances involving the quarantining or hospitalization of at least ten percent of the total population of youth or staff. Five pre-service training records were reviewed and all five staff had training on the program's exposure and infectious control plan and practices. An interview with the FA confirmed a copy of the exposure control plan is maintained in master control, the kitchen, medical clinic, and maintenance.

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.	

The program has a policy and procedures on prenatal care and education of pregnant youth. During the week of the annual compliance review, one pregnant youth was admitted on November 5, 2019. There were no other applicable youth records available. The youth was placed on alert. Prenatal care began on the day of admission and a plan of care was documented. In-service education was provided by a registered nurse (RN). Education included training on monitoring and observation of emergency needs of the pregnant youth, alcohol and drug use, smoking, nutrition, sexually transmitted infections, contraception, prenatal care, birthing process, postpartum care, basic baby care, child/infant development, and parenting skills. Human immunodeficiency virus (HIV) education was provided to the youth and testing was offered. The youth has not been in the program for thirty days but is scheduled to see the designated health authority (DHA) at least monthly. All non-healthcare staff received training from an RN on pregnant youth on September 18, 2019. An interview with the nurse confirmed youth receive prenatal, obstetrical, or gynecological services when needed.

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.	

During the annual review period, observation of supervision of youth was completed on each day. Staff were observed interacting professionally with youth. Staff were aware of how many youth were under their supervision. The staff reported youth counts throughout the day over the radio and requested clearance from master control prior to any movement with the total youth in their custody were observed. Two staff were always observed with the youth. The staff was within the one to eight ratio as required by the contract and the program's policy.

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 policy and procedures for the behavior management system (BMS). The BMS levels and requirements are posted in the day room and dining hall. Youth are provided information regarding the BMS during orientation and the information is in the youth's handbook. Five youth and five staff Interviews indicated both youth and staff were able to explain positive and negative consequences for behavior. Staff are trained on behavior management as part of their on the job training. Interviewed staff stated rewards and consequences are a four to one ratio. Youth stated rewards include outings, nacho/taco bars, and canteen. Consequences includes the emergency treatment team and can range from a consequence packet to level suspension.

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 utilizes point sheets which are reviewed by supervisors to determine adequate and appropriate application of the behavior management system (BMS). The program does not

utilize room restriction with youth. During “All Staff” meetings, training is conducted on the BMS and part of the staff evaluation process is their application of and understanding of the BMS.

5.04 Ten-Minute Checks (Critical)	Satisfactory 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 operates on two shifts. Youth are in sleeping quarters during the second shift. Video surveillances of ten-minute checks were observed during multiple dates for different hour ranges. All checks were observed being conducted within ten minutes. Ten-minute check sheets were also reviewed and documented accurate entries in real time for when checks were conducted. All five interviewed staff indicated they understand checks are conducted within ten minutes of the previous check.

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 utilizes an alert board which contains census, medical, mental health, and security alerts. The master control maintains a logbook and logs hourly head counts, formal head counts, and movement of youth. Observation of youth movements confirmed the program’s policy, procedures, and practice are being followed. A review of the logbook found documentation of youth admissions, discharges, and when youth leave and return to the facility. The program conducts counts at various times throughout the day. The program also conducts counts at the end of each shift, after each outdoor activity, and during escapes or other emergency incidents. The counts were reported over the radio and staff responded accurately with the number of youth under their supervision.

5.06 Logbook Entries and Shift Report Review	Satisfactory 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.	

Four master control logbooks were reviewed. The program maintains one master control logbook for the facility. All important events, counts, and tracking are documented in the logbooks. The program's logbooks were spiral bound and numbered. The logbooks contained all required information such as the supervisors review and comment of the log at the end of the shift, the oncoming supervisor documents their review of the log, and staff also sign their acknowledgement of reviewing the facility log upon change of shift.

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 utilizes a secured key box only master control can access. Administrative staff have assigned key sets. All keys are labeled with the keyset name and the number of keys on the set. The facility master control operator issues keys and secure staff keys in the key box. Staff sign-out their assigned keys in the key log. Visitors keys are maintained in the key box and are provided a chit to account for their keys. An interview with three staff members were able to explain the key process. The program had one Central Communications Center incident during the annual compliance review period which a set of permanent keys were stolen from a staff's personal property. The program rekeyed the facility following the incident.

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 has a contraband policy and procedures which lists the types of items considered contraband. Searches are conducted prior to movement and reported to master control. The facility administrator is aware of how to handle contraband concerns. Staff document dorm contraband checks and how the contraband was handled. There were no illegal contraband confiscated during the annual compliance review period.

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.	

Observation of searches of youth were conducted twice during the week of the annual compliance review. The youth were observed during group movements to classroom from the break/lunch area. The staff systemically searched the youth in quadrants. No observations of full body visual searches were observed. Five staff interviews indicated searches are conducted on every movement. Five youth interviews indicated searches are conducted after meals, visitation, after outdoor activities, and when returning to campus. Two interviewed youth indicated searches are conducted after every movement.

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 has two vehicles utilized for transport. Vehicles are equipped with a seat belt cutter, window punch, and a fire extinguisher. Inside the facility are two emergency kits

prepared with the hazard kits, flashlights, and a first aid kit. All vehicles had the appropriate amount of seat belts and the rear passenger doors were not able to be opened from the inside. Vehicle maintenance records were reviewed and it was observed preventative maintenance inspections are completed, as required. Service records indicated maintenance issues such as oil changes are addressed, as required. Daily random checks of personal and facility vehicles were conducted. All vehicles were properly secured and locked.

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 contract requires a one to five ratio when youth are in the community. The logbook documentation indicated staff to youth ratio was maintained during transport. The program's transportation policy clearly states the responsibilities of all staff when transporting youth. Five staff interviews indicated staff are assigned a cell phone and radio while on transport. The program's transport policy prohibits youth from driving vehicles, youth left unsupervised, seat belts must be worn by both staff and youth, and vehicles are secured when not in use. All staff interviews stated youth are not allowed to be transported in personal vehicles.

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

Weekly safety and security audits are conducted by the assistant facility administrator. Safety and security audits are reviewed the facility administrator (FA) and deficiencies identified are placed on a corrective action plan. A binder is maintained with all the safety and security audits. The program confers with the Department to determine how to proceed to address deficiencies on the corrective action plan and was able to provide examples of issues addressed and the follow-up results. An interview with the FA confirmed the FA reviews the weekly safety and security audits weekly.

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.	

Tools are maintained on a shadow board in the maintenance office. Items are numbered and placed on a shadow board. A review of items found tools were present and accounted for. A tool sign-out form is completed when tools are utilized. A daily inventory is completed by the physical plant manager and signed off at the end of the month.

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.	

Youth and staff interviews indicates youth have access to class B tools which are tools for housekeeping and do not pose a significant security risk. The program's policy maintains youth with a documented security assessment have a lack of readiness to safely use class B tools are

prohibited from such activities. A risk assessment completed at intake for the use of tools is in the youth record.

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 maintains an outside contractor log. The contractor log requires the contractor to review the policy regarding equipment, to document their business, and to document any equipment they are entering the facility with. The program's policy states restrictions on the contractor from access to the youth as much as possible. The policy also list searching for contrabands in the area where the contractor was working after the work is completed.

5.16 Fire, Safety, and Evacuation Drills	Satisfactory 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 conducts monthly fire, safety, and evacuation drills. Drill documentation is maintained in a binder. Five Interviewed youth and five interviewed staff indicated drills are conducted monthly. All youth responded positively they have been instructed on what to do in the event of a fire. Egress plans are posted within the facility with egress points notated. All program fire extinguishers were inspected this year by a fire equipment company and the State Fire Marshall inspection was completed with no noted deficiencies.

5.17 Disaster and Continuity of Operations Planning	Satisfactory 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 combined disaster and Continuity of Operations Plan (COOP) plan containing all required documentation for a COOP plan. The program's COOP plan was updated and approved by the facility administrator and the regional director prior to June 30th. COOP drills were conducted as required. The COOP is maintained in master control and all staff have access to the plan. A copy of the plan is stored in a binder in the front area of the lobby with required youth information for easy access. The program has practiced evacuation drills and has a plan in place to remove all youth records in the event of an evacuation.

5.18 Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Limited 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 inventory of flammable, toxic, poisonous, and toxic items. A program wide inventory is maintained and the program has Safety Data Sheet (SDS) binders located in areas where chemicals are maintained. A review of the SDS books and items on-site in the specified locations, lacked multiple items present upon inspection of the laundry room and shed locations. Inventories of the items present did not account for all items present. No inventory was present for the flammable cabinet. The SDS binders and the issue with the flammable closet inventory were corrected on-site.

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.*	

The program maintains flammable, poisonous, and toxic items in secured areas with limited access. The program's policy limits handling of chemical solutions to youth care workers. During the week of the annual compliance review, there were no youth cleaning areas within the program to observe. All five interviewed youth indicated they do not handle chemicals.

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 means for disposals of flammable, toxic, caustic, and poisonous items. The program has a grease container for kitchen waste. The program has a mop sink for disposal of cleaning agents. The program's policy has a plan for addressing chemical spill and the plant manager was familiar with the policy. An interview with the facility administrator indicated disposal of all flammable, toxic, caustic, and poisonous items will be disposed of by the hazardous waste center.

5.21 Elements of the Water Safety Plan, Staff Training, and Swim Test (Critical)	Non-Applicable

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 does not participate in any water-related activities; therefore, this indicator rates as non-applicable.

5.22 Visitation and Communication	Satisfactory Compliance

The program allows visitation and communication for youth while in the program.

The program conducts visitations on Saturday's. A review of the visitation log indicated visitation occurs on Saturday's from 1:00 p.m. to 3:00 p.m. Observation of the program's visitation schedule was posted within the facility. The program's policy allows for a minimum of two letters a week. The program encourages youth to write two letters home a month. Five youth interviews indicated they are allowed telephone calls and visitation.

5.23 Search and Inspection of Controlled Observation Room	Non-Applicable
The program shall conduct youth searches and room inspections prior to placing a youth on Controlled Observation.	

The program's policy, procedures, and practice confirmed the program does not use controlled observation; therefore, this indicator rates 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's policy, procedures, and practice confirmed the program does not use controlled observation; therefore, this indicator rates 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's policy, procedures, and practice confirmed the program does not use controlled observation; therefore, this indicator rates as non-applicable.

5.26 Safety Planning Process for Youth	Limited 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 maintains safety plans for each youth in the program in a safety plan binder which is maintained in master control. The safety plans have documented information regarding youth triggers, warning signs, and ways youth cope with triggers. The safety plan did not have a place for parent/guardian or recommendations from previous clinical assessments or instruments. Treatment plans were reviewed within thirty days for three of the five records reviewed. Two youth initial treatment plans were two to three days late. The program provided information to confirm the safety plan is reviewed during treatment team and previous diagnosis information is maintained with the treatment team documentation. Five staff interview responses to the process for reviewing safety plans varied and included the review in case management, in meetings, in master control, unsure, and when needed, staff will relay the information.