STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

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

Review Date(s): December 11-14, 2018

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 that 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 that 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 that 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:

Amy Tyson, Office of Program Accountability, Lead Reviewer (Standard 1)
LeAnn Gruentzel, DJJ Probation, Circuit 4, Juvenile Probation Officer (Standard 2)
Robert Loyd, Alachua Regional Juvenile Detention Center, Assistant Superintendent (Standard 5)
Patrick McKinstry, Office of Program Accountability, Regional Monitor (Standard 3)
Jennifer Schad, Office of Program Accountability, Regional Monitor (Standard 4)
Devon Whitten, DJJ Probation, Circuit 4, Juvenile Probation Officer (Interviews)

Program Name: Alachua Academy
Provider Name: Sequel TSI of Florida, LLC
Location: Alachua County / Circuit 8
Review Date(s): December 11-14, 2018

MQI Program Code: 1165
Contract Number: 10189
Number of Beds: 28
Lead Reviewer Code: 157

Methodology

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.

Persons Interviewed

☒ Program Director
☐ DJJ Monitor
☒ DHA or designee
☒ DMHCA or designee
_____ # Case Managers

_____ # Clinical Staff
_____ # Food Service Personnel
_____ # Healthcare Staff
1 # Maintenance Personnel
_____ # Program Supervisors

5 # Staff
5 # Youth
_____ # Other (listed by title): _____

Documents Reviewed

☐ Accreditation Reports
☒ Affidavit of Good Moral Character
☒ CCC Reports
☐ Confinement Reports
☒ Continuity of Operation Plan
☐ Contract Monitoring Reports
☐ Contract Scope of Services
☒ Egress Plans
☒ Escape Notification/Logs
☒ Exposure Control Plan
☒ Fire Drill Log
☒ Fire Inspection Report

☒ Fire Prevention Plan
☒ Grievance Process/Records
☒ Key Control Log
☒ Logbooks
☒ Medical and Mental Health Alerts
☒ PAR Reports
☒ Precautionary Observation Logs
☒ Program Schedules
☒ Sick Call Logs
☐ Supplemental Contracts
☒ Table of Organization
☒ Telephone Logs

☒ Vehicle Inspection Reports
☒ Visitation Logs
☒ Youth Handbook
5 # Health Records
5 # MH/SA Records
5 # Personnel Records
6 # Training Records/CORE
3 # Youth Records (Closed)
5 # Youth Records (Open)
_____ # Other: _____

Interviews

5 # Youth
5 # Direct Care Staff
_____ # Other: _____

Observations During Review

☐ Admissions
☐ Confinement
☒ Facility and Grounds
☒ First Aid Kit(s)
☐ Group
☒ Meals
☒ Medical Clinic
☒ Medication Administration

☒ Posting of Abuse Hotline
☒ Program Activities
☒ Recreation
☒ Searches
☒ Security Video Tapes
☐ Sick Call
☒ Social Skill Modeling by Staff
☒ Staff Interactions with Youth

☒ Staff Supervision of Youth
☒ Tool Inventory and Storage
☒ Toxic Item Inventory and Storage
☐ Transition/Exit Conferences
☐ Treatment Team Meetings
☐ Use of Mechanical Restraints
☒ Youth Movement and Counts

Comments

Items not marked were either not applicable or not available for review.

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	Failed
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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

Standard 2 - Assessment and Performance Plan		
2.01	Initial Contacts to Parent/Gaurdian and Court Notification	Satisfactory
2.02	Youth Orientation	Satisfactory
2.03	Written Consent of Youth Eighteen or Older	Satisfactory
2.04	Classification Factors, Procedures, and Reassessment for Activities	Satisfactory
2.05	Gang Identification: Notification of Law Enforcement	Satisfactory
2.06	Gang Identification: Prevention and Intervention Activities	Satisfactory
2.07	R-PACT Assessment and Reassessments	Satisfactory
2.08	Youth Needs Assessment Summary	Satisfactory
2.09	*Performance Plan Development, Goals and Transmittal	Satisfactory
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	Limited
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	Limited
2.21	Exit Conference	Satisfactory

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory
3.02	* Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory
3.03	Non-Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory
3.04	Mental Health and Substance Abuse Admission Screening	Limited
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	Non-Applicable

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	* Designated Health Authority/Designee	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification	Satisfactory
4.05	Notification - Clinical Psychotropic Progress Note	Satisfactory
4.06	Immunizations	Satisfactory
4.07	Healthcare Admission Screening Form	Satisfactory
4.08	Medical Alerts	Satisfactory
4.09	Youth Orientation to Healthcare Services	Satisfactory
4.10	Designated Health Authority/Designee Admission Notification	Satisfactory
4.11	Healthcare Admission Rescreening	Satisfactory
4.12	Health Related History	Satisfactory
4.13	Comprehensive Physical Assessment	Satisfactory
4.14	Female-Specific Screening/Examination	Satisfactory
4.15	Tuberculosis Screening	Satisfactory
4.16	Sexually Transmitted Infection Screening	Satisfactory
4.17	HIV Testing	Satisfactory
4.18	Sick Call Process - Requests/Complaints	Satisfactory
4.19	Sick Call Process - Visits/Encounters	Satisfactory
4.20	Restricted Housing	Non-Applicable
4.21	Episodic/First Aid Care	Satisfactory
4.22	Emergency Care	Satisfactory
4.23	Off-Site Care/Referrals	Satisfactory
4.24	Chronic Illness/Periodic Evaluations	Satisfactory
4.25	Medication Management - Verification	Satisfactory
4.26	Medication Management - Orders/Prescriptions	Satisfactory
4.27	Medication Management - Storage	Satisfactory
4.28	Medication Management - Medication and Sharps Inventory	Satisfactory
4.29	Medication Management - Controlled Medications	Satisfactory
4.30	Medication Management - Medication Administration Record	Satisfactory
4.31	Medication Management - Medication Administration By Licensed Staff	Satisfactory
4.32	Medication Management - Medication Provided By Non-Licensed Staff	Satisfactory
4.33	Medication Management - Psychotropic Medication Monitoring	Satisfactory
4.34	Infection Control - Surveillance, Screening, and Management	Satisfactory
4.35	Infection Control - Education	Satisfactory
4.36	Infection Control - Exposure Control Plan	Satisfactory
4.37	Prenatal Care - Physical Care of Pregnant Youth	Satisfactory
4.38	Prenatal and Neonatal Care - Nutrition, Education of Youth, and Lactation	Satisfactory
4.39	Prenatal and Neonatal Staff Education	Limited

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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	Satisfactory
5.19	Youth Handlins 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	Recreation and Leisure Activities	Satisfactory
5.22	*Elements of the Water Safety Plan, Staff Training, and Swim Test	Non-Applicable
5.23	Visitation and Communication	Satisfactory
5.24	Search and Inspection of Controlled Observation Room	Non-Applicable
5.25	Controlled Observation	Non-Applicable
5.26	Controlled Observation Safety Checks and Release Procedures	Non-Applicable

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Standard 1: Management Accountability

Overview

Alachua Academy is located in Gainesville, Florida in a building owned by the Department. The program is a twenty-eight bed, non-secure residential treatment program which serves females, ages twelve to eighteen, who are in need of substance abuse treatment overlay services (SAOS). Additionally, the program provides youth with medical care, mental health services, and educational services. Since the last annual compliance review, the administration has changed to include the program director, assistant facility administrator, and the clinical director. There were no vacancies at the time of the annual compliance review.

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. A contract provider may hire an employee to a position that 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 that he or she exhibits no behaviors that warrant the denial or termination of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

The program has a policy and procedures in place regarding initial background screenings. Initial background screenings are conducted for all new employees, interns, volunteers, and mentors. Twenty-nine staff were hired since the last annual compliance review and each had a background screening completed prior to their start date. Additionally, fourteen of the employees hired were direct care staff eligible for a pre-employment assessment tool. Each of the fourteen completed the pre-employment assessment tool and received a passing score. The program also review 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 results. The Annual Affidavit of Compliance with Level 2 Screening Standards was completed and sent to the Background Screening Unit on November 2, 2017, meeting the annual requirement.

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 regarding a five-year rescreening based on the initial date of employment. One employee was eligible for a five-year rescreening, which was completed at the five-year date.

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

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

- *Posting of the Florida Abuse Hotline telephone number and the Central Communications Center for youth 18 years of age and older telephone number.*
- *All allegations of child abuse or suspected child abuse are 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.*
- *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.*

The program has a policy and procedures in place regarding the provision of an abuse-free environment. The program's facility operating procedures state the program will comply with and support the Department's policy on abuse reporting, all allegations of child abuse or suspected child abuse will be immediately reported to the Florida Abuse Hotline and the Department's Central Communications Center (CCC) within two hours of the incident. All staff are to be trained in reporting procedures. The policy also states the program will allow unhindered access for youth and staff to make the decision to report allegations of abuse. Youth are granted immediate access if they request to make a call. Youth must go through staff to obtain use of a telephone, staff will dial the number and then permit the youth to speak with the operator. At the conclusion of the call, the staff member will speak with the operator to get the operator identification number and incident number, if one is assigned. The youth then returns to their group. The on-duty supervisor is responsible for notifying the program director of the incident and contacting the CCC. A review of incidents since the last annual compliance review reflected fourteen calls to the abuse registry. Of those incidents, two were substantiated, with one staff receiving retraining and a written reprimand and the other staff being terminated. Five youth were interviewed, and all reported they feel safe and have never been denied a call to the Florida Abuse Hotline. When the five youth were asked if they've heard staff use profanity one said never, one said once, two said occasionally, and one reported often. The program director explained, "Sequel prides itself on "doing the right thing" which is why we ensure staff are trained on how to appropriately interact with youth and one another. If there are reportable incidents which occur, staff are trained to report those incidents immediately. If there is imminent danger, staff will be removed from youth contact. If there is an opportunity for re-training, we will utilize this opportunity to do so."

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 had two incidents of substantiated abuse since the last annual compliance review. During all investigations, staff were removed from contact with the youth. In one incident, the staff was terminated and in the other incident, the staff received a written reprimand and retraining. The program director confirmed the disciplinary actions taken in response to the substantiated incidents.

1.05 Incident Reporting (CCC) (Critical)	Satisfactory Compliance
Whenever a reportable incident occurs, the program notifies the Department's Central Communications Center (CCC) within two hours of the incident, or within two hours of becoming aware of the incident.	

The program has a policy and procedures for reporting incidents to the Central Communications Center (CCC). There were twenty incidents reported to the CCC in the past six months. Five of these calls were reviewed and found each incident was reported to the CCC within two hours. Two of the five CCC reports were also documented in the logbooks. The remaining three incidents reviewed were documented in shift reports. There were no internal incidents or grievances which should have been reported to the CCC and were not. The program has not experienced an increase in the number of reportable incidents to the CCC. The program director explained if a reportable incident occurs, the Florida Abuse Hotline is notified, as well as the CCC, and if warranted, the police department is notified. All notifications must be made within the two-hour timeframe. If the incident is Prison Rape Elimination Act (PREA) related, the PREA policy will be implemented. Additionally, both pre and in-service training includes incident reporting, where the program's policy is reviewed. Youth are informed of the reporting process through the orientation and intake process, as well as during townhall meetings.

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 for the first quarter of the fiscal year is 0.0, which is below the statewide average of 1.55. There were six PAR incidents in the past six months; five of these incidents were reviewed. In four of five reports reviewed, the report was completed by the end of the staff member's workday and included statements from all staff involved. None of the reports reviewed documented injuries to the youth or staff, nor did the youth allege abuse. In four of five reports reviewed, a PAR

certified instructor or supervisory staff completed a review and a post-PAR interview with the youth was conducted, all completed within the required timeframes. One report was incomplete and only included the statement from the staff member involved. It did not include a review by a PAR certified instructor or supervisory staff, Post-PAR interview with the youth, or a review of the incident by the administrator or designee. In all reports reviewed, the report was placed in a central file. The program director stated PAR reports are completed and reviewed utilizing CCTV, if footage is available, to ensure staff are properly utilizing techniques according to policy. If a staff is found using excessive or unnecessary force, they will be removed from youth contact pending further investigation and the incident will be reported to the Central Communications Center (CCC), if warranted.

1.07 Pre-Service/Certification Requirements (Critical)	**Satisfactory Compliance**
Contracted and State residential 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 regarding pre-service training requirements for 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 January 30, 2018. 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	**Failed Compliance**
Residential 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 regarding in-service training requirements for staff. The program had one staff member who was eligible to complete in-service training. Documentation reflected no training was completed by the staff. The program provided the in-service training calendar for 2017 which reflected the schedule of trainings; however, had no sign in sheets or other documentation to support the training occurred. 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 January 30, 2018.

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, regarding the 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 not resolved through the informal phase, the youth may submit 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, it may be appealed to the assistant facility administrator, who will have twenty-four hours to respond, and then the program director, who has forty-eight hours to respond. The program maintains copies of the grievances in a grievance binder. In the past six months, there have been twenty grievances filed, of which five were reviewed. All five grievances reviewed were resolved during the formal phase and within twenty-four hours of the youth filing the grievance. Five youth were interviewed and were able to explain the process for completing a grievance. One youth reported the program director is to respond to grievances within twenty-four hours, but most times it takes three to four days. The documentation in the grievance binder contradicted this statement, as all grievance were resolved within twenty-four hours. Five staff were interviewed and all five reported youth may request assistance in completing the grievance form. Additionally, four staff stated forms are placed throughout the program, a supervisor reviews the grievance, and the program director reviews the grievance. Three staff indicated the grievance process has three phases. The program director confirmed the process for grievances to include three phases and the timeframes associated with each phase.

1.10 Delinquency Interventions and Facilitator Training	Satisfactory Compliance
The program shall implement a delinquency intervention model or strategy that is an evidence-based practice, promising practice, or a practice with demonstrated effectiveness, for each youth. Staff whose regularly assigned job duties include implementation of a specific delinquency intervention model, strategy, or curriculum receive training in its effective implementation.	

The program has a policy and procedures regarding delinquency interventions and facilitator training. The program director explained when determining which staff will deliver life skills trainings or groups, education and experience are considered. Additionally, she stated youth are assigned to the perspective 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, Voices, and Living in Balance received the required training to facilitate the group. A review of sign-in sheets confirmed groups were delivered, as required.

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

The program has a policy and procedures regarding life skills training provided to youth. There are groups scheduled daily, Monday through Sunday. Five youth records were reviewed, and 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 to include Voices and Living in Balance. 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 groups 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 regarding restorative justice awareness for youth. 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 also teaches youth about the impact of crime on victims, their families, and their communities and exposes youth to victim's perspectives. The youth are also provided opportunities to plan and participate in restitution activities and community service projects. The youth currently make blankets which are then donated to homeless shelters. Two case managers are currently providing the IOC curriculum and have received the required training in order to do so. Group sign-in sheets supported the curriculum was delivered, as designed. Five youth records were reviewed, and documentation supported they received services to increase their accountability for criminal actions and harm to others. The program director further explained youth participate in IOC groups, which occur on Tuesdays and Thursdays or Mondays and Wednesdays according to the facilitator. Youth are able to participate in community service activities; they participate in community service activities at "Bread of the Mighty" food bank at least once a month and have donated Easter Baskets to the local church.

1.13 Gender-Specific Programming	Satisfactory Compliance
The program provides delinquency intervention and gender-specific treatment services.	

The program provides gender-specific programming using 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 is based on the realities of 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 program director explained management reviews alerts daily and as new alerts are identified. The program has an internal alert log where the youths' pictures are posted with a color coded system to identify various alerts. There is also an alert log which is updated, as needed, and posted in master control and kitchen. Alerts are also documented in the log book if an incident occurs on 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 who had alerts for suicide risk entered in to JJIS reflected the alert was updated and removed, as required by the clinical director. A comparison of internal alerts and alerts in JJIS reflected no inconsistencies. Four of five youth reviewed had medication alerts which were entered into JJIS late. The issue with alerts was identified and brought to the attention of the program in October 2018. Since then, the program has implemented new procedures to correct this issue.

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 the following sections: 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 which addresses a formal process to promote constructive input by youth. The program accomplishes this through youth advisory board meetings and townhall meetings. Five youth were interviewed regarding how they are able to provide input into programming. All five youth indicated they use Speak Out forms to voice

concerns. The program director indicated youth complete monthly surveys, as well as exit surveys as a way to make recommendations for resolution to improve conditions and enhance the quality of life for staff and youth in the program. Additionally, the program director indicated community meetings/townhall meetings are conducted to provide youth a forum to voice their concerns, issues, and program feedback on a monthly basis or as special needs arise.

1.17 Advisory Board	**Satisfactory Compliance**
The program has a community support group or advisory board meeting at least quarterly. The program director solicits active involvement of interested community partners.	

The program has a policy and procedures regarding the community advisory board. The program director explained 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. Documentation supported the program director solicits active involvement from law enforcement, community partners, school board, faith community, victim advocate, and a parent/guardian whose child was recently released from the program. Meetings were scheduled in July and October. 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 program director explained all-staff meetings are held once a month and on an as-needed basis, and supervisors are informally updated of any development changes. Additionally, to assist with employee morale, the program has an employee of the month and weekly staff appreciation events. The program director explained how data is used for future program planning including the use of youth and parent surveys and employee satisfaction surveys. Results are discussed with staff and improvements are made with any deficiencies noted. Pertinent information, such as published reports, are discussed during monthly staff meetings. Five staff were interviewed, and all responded staff meetings are held monthly. Staff reported discussed topics included the behavior management system, day-to-day operations, upcoming trainings, and dress code. Four of the five staff confirmed they are briefed on reports, annual compliance reports, and youth and parent surveys. One stated they are only informed if there is a significant issue. One of the staff reported communication within the program is fair, three reported good, and one reported very good. Documentation supported monthly staff meetings are held to inform staff on various topics such as behavior management system, grievance procedures, evaluation sheets, key control, etc. Additionally, monthly management meetings are held for administrative staff to review department updates.

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 regarding staff performance and evaluations, which states staff will be evaluated after their initial ninety-day probationary period and annually thereafter. A review of five personnel records found each contained copies of job descriptions

which clearly identified the staff member's performance standards. A review of five performance evaluations reflected they were completed in a timely manner (at the ninety-day mark for those who had not been employed a year and annually for those who were employed a year or more). The performance standards matched the job descriptions for each staff. The evaluation form also includes a section for those staff members who facilitate an evidenced based group. Five staff members were interviewed and all five reported receiving a ninety-day performance evaluation and a performance evaluation annually.

Standard 2: Assessment and Performance Plan

Overview

The program employs two case managers and one director of case management. The case manager is designated as the treatment team leader. The case managers are responsible for completing the Residential Positive Achievement Change Tool (R-PACT) within thirty days of each youth's admission date and every ninety days thereafter. The case managers are responsible for completing the Youth Needs Assessment Summary (YNAS), developing the performance plans, completing performance summaries, coordinating formal and informal treatment team meetings, and transition planning. The case managers also facilitate prevention groups, visitation, weekly telephone calls, and supportive counseling for youth and their parents/guardians. The case managers have a system which tracks the due dates of all required case management documentation. All case managers maintain chorological notes for each youth on their caseload.

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

The program has a policy and procedures to notify each youth's parent/guardian by telephone within twenty-four hours and to send written notification to their parent/guardian, committing judge, juvenile probation officer (JPO), and post-residential counselor (if applicable) within five working days of admission to the program. Four of the five reviewed case management records indicated parent/guardians were notified by telephone during the intake process. One case management record did not indicate the youth's parent/guardian was notified by telephone. All five case management records indicated the judge and parents/guardians were sent written notifications of admission within five working days. Four case management records indicated the JPO was notified by written notification of admission within five working days. One case management record did not indicate the JPO was sent written notification.

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

The program has a policy and procedures to provide each youth with an orientation to the program on the day of admission. The program utilizes an orientation checklist to explain and discuss program rules, schedules, and services available to the youth. All five reviewed case management records indicated the youth received an orientation and the orientation checklist was signed by each youth to document they received the orientation. Five youth were interviewed, and each reported they received an orientation to the program within twenty-four hours of arrival. The youth were also able to describe the orientation process which included meeting with the nurse, mental health staff, case management, and reviewing intake paperwork.

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

The program has a policy and procedures to have all youth eighteen years of age or older to sign consent forms on the day of admission or at the time of the youth's eighteenth birthday, should they still be in the program. Two of the case management records reviewed were applicable for youth eighteen years old or older. Both records contained 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 that may be used as potential weapons or means of escape, or participation in any off-campus activity.*	

The program has a policy and procedures utilizing a classification system to assign a youth to a living and/or sleeping room on the day of admission. The program reviews classification factors such as physical characteristics, age and maturity, special needs, history of violence, gang affiliation, criminal behavior, sexual aggression or vulnerability, and identified or suspected risks when assigned. The program has a policy and procedures to reassess and reclassify youth, if warranted, prior to considering an increase in 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, or participation in any off-campus activity. The youth are reviewed for reassessment during their formal treatment team meetings. A continually updated, internal alert system is used and is easily accessible to program staff and keeps them alerted about youth who are security or safety risks, including escape risks, suicide or other mental health risks, medical risks, sexual predator risks, and other assaultive or violent behavior risks. The youth are reviewed for reassessment during their formal treatment team meetings. All five reviewed case management records indicated an initial classification of each youth was reviewed before they were assigned to a living and/or sleeping room and reassessments of youth were completed, if warranted.

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

The program has a policy and procedures in place for gathering information on gangs and to share information with law enforcement, both local and in-home county, education provider, juvenile probation officer (JPO), and aftercare counselor. There were no applicable active or closed case management records available to review regarding gang identification; however,

the program's process for notifying law enforcement was reviewed and the program showed the letters they would send, if the situation arises.

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.	

There were no applicable active or closed case management records available to review applicable for gang intervention activities; however, the program does provide gang prevention strategies to all youth. The program utilizes videos, pamphlets, and discussions to provide gang prevention/awareness to all youth at the program.

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

The program has a policy and procedures to assess each youth using the Residential Positive Achievement Change Tool (R-PACT) within thirty days of admission and reassessments within ninety days thereafter. Four of the five reviewed case management records indicated the youth were assessed within thirty days of arrival to the program and all documentation of the process was maintained in the Department's Juvenile Justice Information System (JJIS). The remaining case management record indicated the assessment was completed eleven days late. Three of the five case management records reviewed were applicable for an R-PACT reassessment. One case management record indicated the reassessment was completed within ninety days. Two case management records indicated the reassessments were each completed ten days late.

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 YNAS.	

The program has a policy and procedures requiring the completion of a Youth Needs Assessment Summary (YNAS) for each youth to be conducted within thirty days of admission. Three of the five reviewed case management records indicated each youth had a YNAS completed within thirty days of admission to the program and all documentation was maintained in the Department's Juvenile Justice Information System (JJIS). Two case management records indicated the assessments were completed twenty-six and thirteen days late. The program maintains all reassessment documentation in each youth's case record.

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 and procedures requiring the intervention and treatment team, including the youth, to meet and develop the youth's performance plan, stipulating goals, which are measurable, individualized, and prioritize needs, the youth shall achieve prior to release from the program. The performance plan is to be developed and signed within thirty days of admission. Two of the five reviewed youth case management records indicated the performance plans were completed within thirty days. Three youth case management records indicated the performance plans were completed nine, thirteen, and forty-six days late. Four of the youth case management records indicated the treatment team signed the performance plans and indicated the parents/guardians and juvenile probation officers (JPO) were sent letters requesting their signature on the performance plan and to return to the program. Five youth were interviewed regarding the program's process for development of the performance plan, treatment meetings, and goals they were currently working on. Each youth was able to explain the process to include meeting with their case manager, identifying strengths and weaknesses, and a discussion of long term and short-term goals. Four youth stated they had copies of their performance plans.

2.10 Performance Plan Revisions	Satisfactory Compliance

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

The program has a policy and procedures allowing the intervention and treatment team to revise a youth's individualized performance plan based on the R-PACT reassessment results, the youth's demonstrated progress or lack of progress toward completing a goal, or newly acquired or revealed information. Two of the five reviewed youth records indicated each of the youth's performance plans were revised based on progress. Three of the five youth 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 and procedures requiring the intervention and treatment team to 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, and to distribute them within ten working days of signing. One of the five reviewed youth case management records had documentation indicating the performance summary was completed within the ninety-day timeframe. Two youth case management records performance summaries which were completed ten days and two months late, and one case management record reviewed showed a performance summary without any summary components, almost completely blank. All summaries were reviewed and signed by all required parties. Two youth case management records showed the summaries were sent to the judge, juvenile probation officer (JPO), and parent/guardian within ten working days, with a copy being given to youth. One youth case management record did not indicate the summary was sent to judge, parent/guardian, or JPO. The intervention and treatment team also prepares performance summaries prior to the youth's release, discharge, or transfer from the program. Three reviewed closed youth case management records showed the summaries were sent within ten working days of signature; however, the program did not send out pre-release notification (PRN) and release summaries within the forty-five-day timeframe before release. Five youth were interviewed and two reported they received a copy of the performance summary sent to the court, for one this question was not applicable.

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

The program has a policy and procedures to encourage and facilitate the involvement of the youth's parent/guardian in the case management process. The program invites each youth's parent/guardian to participate in the intervention and treatment team meetings for the purpose of developing the youth's performance plan. The program also mails treatment team letters to the parents/guardians, inviting them to attend the monthly treatment team meetings. If unable to attend, the program gives the parent/guardian the opportunity to participate by telephone or provide written input prior to the meeting. Parents/guardians are also invited to attend the youth's transition conference and exit staffing when placed in transition. Five reviewed youth case management records indicated, from case notes or signature page, the parents/guardians participated in case management services. Five youth were interviewed and four responded their parents/guardians are involved in their case management. The remaining youth is eighteen years old and can choose whether or not to have her mom on treatment team calls.

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.	

All five youth case management records reviewed documented all required treatment team members were actively participating in the process. The treatment team members consist of the youth, case manager, representatives from the program's administration and residential living unit, education, therapist, juvenile probation officer, the Department of Children and Families, when applicable, and parent/guardian. The case manager is identified as the treatment team leader and coordinates and oversees the team's efforts and facilitates effective management of each case assigned to the team.

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 for the intervention and treatment team to reference or incorporate the youth's treatment plan into the youth's performance plan. Four youth case management records were reviewed, and all performance plans contained the required documentation. The remaining youth case management record reviewed did not reference academic plan in performance plan.

2.15 Treatment Team Meetings (Formal and Informal Reviews)	Satisfactory Compliance
A residential commitment program shall ensure the intervention and treatment team meets every thirty days to review each youth's performance, to include R-PACT 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 progress. *A residential commitment program shall ensure the intervention and treatment team reviews each youth's performance, including R-PACT 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 progress.*	

The program has a policy and procedures for intervention and treatment team to meet formally once every thirty days, and informally bi-weekly to review each youth's performance, to include the Residential Positive Achievement Change Tool (R-PACT) reassessment results, progress on individual performance plan goals, positive and negative behaviors, including behaviors resulting in physical interventions, and a review of the youth's individualized treatment plan. All five youth case management records contained documentation of the treatment team meeting every thirty days for formal treatment team meetings and bi-weekly for informal treatment team meetings. Each formal performance plan review contained the youth's name, date of review, meeting attendees, and any input or comment from the team members, along with a brief synopsis of the youth's progress in the program. Documentation reflected the meeting attendees which included the youth, representatives from administration and living unit, and others directly responsible for providing, or overseeing provision of, intervention and treatment services.

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

The program offers Type 2 vocational education and age appropriate educational program. The youth learn how to develop resumes and fill out job applications as part of their educational curriculum and learn interviewing skills as part of their life skills class. Three closed youth case management records were reviewed, and all had samples of employment applications and resumes; however, none had a calendar/scheduled appointment with Career Source. Documentation reflected the youth's parent/guardian and JPO were aware of the youth's vocational plan. Interview with the program director reflected youth are offered a variety of career or vocation services in the facility to include: ServSafe, Florida Shine, and Florida Ready to Work.

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

The program operates on a year-round basis, with at least 250 days of instruction, distributed over twelve months; a minimum of twenty-five hours of instruction weekly, which has a daily schedule. Five youth were asked if there are a lot of interruptions during educational instruction four youth indicated yes, and explained other youth in the class can be disruptive. Logbooks were reviewed and reflected education classes are taking place as scheduled. No deviations from the education schedule were noted. The principal confirmed the education instruction schedule is followed by the program.

2.18 Education Transition Plan	Satisfactory Compliance
Staff and youth complete an education transition plan upon entry including provisions for continuation of education and/or employment.	

Three closed youth case management records were reviewed for educational transition plans. All records included copies of youth's education history, job applications, resumes, and other pertinent paperwork needed to enroll in school or workforce once they return into the community, and vocational certifications they might have earned while in the program. In all three plans the following items were addressed: services and intervention based on the student's assessed educational needs and post-release education plans, the recommended educational placement for post release was based on individual needs and performance, specific monitoring responsibilities by individuals who are responsible for the reintegration and coordination of the provision of support services, provision for continuation of education and/or employment, a sample completed employment application, a resume summarizing education, work experience, and/or career training, and evidence the youth's case manager and parent/guardian were aware of the plan, documents, and post-release discharge plans. The three records did not contain a valid Florida identification card which was due to the youth's families choosing not to send the required original documentation to the program (birth certificate, social security card) for a Florida identification card to be obtained.

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.

Three closed youth case management records were reviewed for transition conference completion. All records indicated the transition conferences were completed within the required timeframes and all appropriate parties were notified of the conference in advance. Required parties, to include the youth, parent/guardian, and treatment team leader, were present or provided their input prior to the conference in all records. The transition plans included appropriate goals and end dates for the youth's release back into the community. All records indicated the Community Re-Entry Team (CRT) meeting was conducted prior to the youth's release.

2.20 Exit Portfolio	Limited 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 closed youth case management records were reviewed for exit portfolios. In all three records, the youth were provided copies of their education records and copies of all certifications earned while in the program. The exit portfolios did not contain a state issued identification card, social security card, or birth certificate. The parents/guardians of the youth did not send the required documents (birth certificate and social security card) to the program. These documents are required to obtain the identification card. Additionally, none of the three youth received a calendar outlining when they should have a curfew, make appointments with Career Services, and other important dates. Program staff forwarded the exit portfolio information to the JPO and this was documented in the youth's case management record. Do not have a reason as to why calendars with Career Source appointments were not completed.

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 closed youth case management records were reviewed for exit conference completion. All three records indicated the youth participated in the exit conference held within the required timeframe. All records indicated the exit conference included the youth's parent/guardian,

treatment team leader, education director, and other pertinent staff essential for the youth's transition back in to the community.

Standard 3: Mental Health and Substance Abuse Services

Overview

The program is contracted to provide twenty-four substance abuse overlay services (SAOS) beds. The scope of SAOS treatment service delivery is outlined within the contract between the provider and the Department. The program provides individual, group, psychiatric, and/or family therapy seven days a week. The program employs a licensed clinical social worker (LCSW), who serves as the designated mental health clinician authority (DMHCA). The LCSW is a full-time employee of the program and is on-site forty hours a week. The program also has three non-licensed mental health clinical staff; two full time and one part-time. The program has an agreement with a psychiatrist, who is on-site bi-weekly, to provide psychiatric services. In addition, the program has an agreement with a licensed mental health counselor (LMHC), who is a board certified behavior analyst (BCBA). The program has written facility operating procedures (FOP) which address mental health and substance abuse service delivery.

3.01 Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory Compliance

Each program director is responsible for the administrative oversight and management of mental health and substance abuse services in the program.
Programs with an operating capacity of 100 or more youth, or those providing specialized treatment services, must have a single licensed mental health professional designated as the Designated Mental Health Clinician Authority (DMHCA) who is responsible for the coordination and implementation of mental health and substance abuse services in the facility/program.

Programs with an operating capacity of fewer than 100 youth or those not providing specialized treatment services, may have either a DMHCA or a Clinical Coordinator.

The program has a licensed clinical social worker (LCSW), who serves as the designated mental health clinician authority (DMHCA). The LCSW is licensed under Chapter 491, Florida Statutes. A review of the LCSW's license was conducted through the Florida Department of Health (DOH), which revealed the license is clear and active, and expires March 31, 2019. The LCSW is employed with the program as a full-time employee and is on-site forty hours a week; sufficient time to ensure appropriate coordination and implementation of mental health and substance abuse treatment services. The LCSW has been the DMHCA since March 2018, after the previous DMHCA resigned in March 2018. A copy of the LCSW's licensure and position description was available for review while on-site. The program provides specialized treatment services; substance abuse overlay services (SAOS) for twenty-eight slots, serving female youth between the ages of twelve to eighteen. All mental health and substance abuse staff licensures and position descriptions are available on-site for review.

An interview with the DMHCA revealed she assists in hiring clinical staff, communicates with administration, therapists, case managers, and youth care workers, reviews clinical charts weekly, and is on-site at least forty hours a week, as well as available by telephone twenty-four hours a day, seven days a week.

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

The program's mental health and substance abuse staffing is in accordance with the program's contract and Florida Administrative Code, 63N-1. The program has a licensed clinical social worker (LCSW), who serves as the designated mental health clinician authority (DMHCA), licensed under chapter 491, Florida Statutes. The program has an agreement with a psychiatrist, who has completed a psychiatry program approved by the by the American Board of Psychiatry and Neurology, licensed under Chapter 459, Florida Statute. The psychiatrist's license is clear and active, verified through DOH, and expires January 31, 2020. The program has a cooperative working agreement with a licensed mental health counselor (LMHC) who is a board certified behavior analyst (BCBA). A review of the LMHC license was conducted through DOH, which revealed the license is clear and active, and expires March 31, 2021. The program is licensed in accordance with Chapter 397, Florida Statute, to provide substance abuse services, certified by the Department of Children and Families (DCF), which expires October 26, 2019. Licensures for all qualified mental health and substance abuse professionals are available for review on-site.

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 program has two full time non-licensed clinical staff and one part-time non-licensed clinical staff, providing mental health and substance abuse services at the program. The clinical supervisor is the designated mental health clinician authority (DMHCA), who is a licensed clinical social worker (LCSW). The DMHCA ensures the three non-licensed clinical staff working under supervision are performing services they are qualified for. This is accomplished through weekly on-site, face-to-face interaction with each of the three non-licensed clinical staff, lasting at least one hour for each contact. A review of twenty-six weekly face-to-face interactions (in a group or individually) were reviewed. All twenty-six face-to-face supervisions occurred, as required. Each of the reviewed face-to-face supervision meetings conducted were recorded on a similar form to MHSA 019, which included all necessary information. All three non-licensed clinical staff hold the appropriate level of education necessary and are in accordance with the contract between the provider and the Department. The three non-licensed clinical staff hold a master's-level degree from an accredited university. The program is licensed under Chapter 397, to provide substance abuse treatment services; certified by the Department of Children and Families (DCF), which expires October 26, 2019. Each of the three non-licensed clinical staff received twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The non-licensed clinical staff's training was documented on the non-licensed mental health clinical staff person's training in Assessment of Suicide Risk (ASR) form MHSA 022.

The DMHCA reviewed and signed each of the five comprehensive mental health and substance abuse evaluations and initial and individualized treatment plans completed by the non-licensed mental health clinical staff. All reviews conducted by the DMHCA occurred within the specified timeframe. Four of the five ASRs were completed by non-licensed mental health clinical staff, which were reviewed by the programs licensed mental health professional. The licensed mental health professional completed the one remaining applicable ASR.

3.04 Mental Health and Substance Abuse Admission Screening	**Limited 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.	

Five youth records were reviewed for a mental health and substance abuse admission screening. Each of the five youth records reviewed had a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) completed upon admission. All available information was reviewed, to include the commitment packet, reports, and records from existing documentation of mental health and/or substance abuse issues. The five MAYSI-2 screenings were completed on date of the youth's admission to the program in a confidential manner. The MAYSI-2 screenings were administered in the Departments Juvenile Justice Information System (JJIS). Two of the five were conducted by staff who had completed the appropriate MAYSI-2 training. The remaining three MAYSI-2 screenings were completed by two separate staff who had not completed training; one staff completed the required training on November 28, 2018 and the other staff completed training on December 12, 2018. The three MAYSI-2 screenings in question, were completed prior to the completion of staff's training; July 30, 2018, September 5, 2018, and October 8, 2018.

Two of the five MAYSI-2 screenings indicated further assessment was required. Pursuant to the program's written policies and procedures, all youth are to receive mental health and substance abuse screenings, including a suicide risk screening, upon admission. All five youth were referred for an Assessment of Suicide Risk (ASR). Each was conducted within twenty-four hours of the referral. There were no indications where staff believed a youth had a mental health or substance abuse problem or was a suicide risk. In addition, there were no indications where staff determined a referral for further evaluation was needed, whereas, the MAYSI-2 does not indicate a referral is necessary; however, the staff enters the information, observations, events, or concerns leading to the determination into the Department's Juvenile Justice Information System (JJIS). One of the five youth administered the MAYSI-2, required the completion of a comprehensive evaluation. The one youth had a reason for referral documented.

A review of the program's written facility operating procedures (FOP) determined the program director is responsible for developing written FOP's for the implementation of a standardized admission or intake mental health and substance abuse screening process. The written FOP's addressed the following: A standardized screening process which included the review of commitment packet information, reports, and records. The administration of the MAYSI-2 on the Department's Juvenile Justice Information System (JJIS). Each screening is conducted by a "qualified professional" and referral made when for youth identified by screenings as in need of further evaluation or immediate attention. The FOP also identified staff training in mental health and substance abuse issues and administration of the MAYSI-2. Also the FOP's identified standardized process for referral of youth identified as in need of further mental health and/or substance abuse evaluation to an appropriate service provider or professional or, when immediate attention is needed, to a hospital or Baker Act or Marchman Act receiving facility.

An interview with the program director revealed the MAYSI-2, ASR, Sexually Aggressive Behavior (VSAB), Beck Depression Inventory-2 (BDI), Substance Abuse Screening Inventory (SASSI), and Suicide Probability Scale (SPS) are all utilized to identify youth at risk for mental health and substance abuse issues and/or suicide.

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.	

Five youth records were reviewed for a mental health and substance abuse assessment/evaluation. Each of the five youth records reviewed had a new mental health evaluation completed within thirty calendar days of admission. All five new mental health evaluations were conducted by a non-licensed mental health clinical staff, and were reviewed and signed within ten days by a licensed mental health professional. The new mental health evaluations contained demographics, reason for evaluation, relevant background information, behavioral observations, mental status examination, discussion of findings, diagnostic impression, and recommendations.

Each of the five reviewed records had a new substance abuse assessment completed. The substance abuse assessments were completed under the programs licensure under Chapter 397. All five youth had a signed consent for substance abuse services. The assessments were completed within thirty calendar days of admission. The new substance abuse assessments contained a reason for evaluation, relevant background information, behavioral observation, methods of assessment, patterns of alcohol and other drug abuse, impact of alcohol and drug abuse, risk factors of continued alcohol and other drug abuse, clinical impression to include diagnose from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-IV-TR) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5) mental disorder, and recommendations. The five new substance abuse assessments addressed the original referral reason.

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.*	

Five youth records were reviewed for mental health and substance abuse treatment. All five youth records indicated the youth were assigned to a treatment team upon arrival to the program. Multidisciplinary treatment teams were comprised of the youth, program administration, a staff from the residential living unit, and other staff responsible for delinquency intervention and treatment services for the youth. In each of the five records reviewed, documentation validated treatment teams were comprised of representatives from administration, education, vocational training, medical staff, mental health staff, substance abuse staff, youth, and, when possible, the youth’s parent/guardian. Each of the five youth were

determined to be in need of substance abuse treatment. The youth were in receipt of individual, group, and family counseling, and/or psychiatric medication management. Substance abuse treatment was provided by a licensed qualified professional or a non-licensed substance abuse clinical staff working under the direct supervision of a licensed mental health professional. All five youth records reviewed were applicable for mental health treatment. The five youth each had a properly executed Authority to Evaluate and Treatment (AET) form. Documentation of a clinical impression to include diagnose from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-IV-TR) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5) mental disorder were included for each of the five youth reviewed. All of the records reviewed for substance abuse treatment contained a signed substance abuse consent and release form; forms were completed on the Department forms MHSA 012 and MHSA 013. Mental health and/or substance abuse treatment notes were completed on the provider's form, which contained all of the required information within Department form MHSA 018. A review of youth sign-in sheets for mental health treatment groups documented the groups did not exceed ten youth. A review of youth sign-in sheets for substance abuse overlay services (SAOS) treatment groups documented the groups were limited to fifteen or fewer youth. Each of the five youth records contained documentation the youth were involved in individual psychotherapy or counseling. Youth were engaged in therapeutic activities designed specifically to address skill deficits or maladaptive behaviors. Substance abuse treatment was provided by a licensed qualified professional or a non-licensed substance abuse clinical staff, who is an employee of a service provider under chapter 397, Florida Statutes.

Interviews with five staff revealed none of them facilitate any mental health or substance abuse groups. An interview was conducted with the program's designated mental health clinician authority (DMHCA). In an interview with the DMHCA, it was determined the program offers substance abuse overlay services (SAOS). On the day of intake, all youth are assigned a primary therapist to deliver these services. The DMHCA keeps a tracker to ensure these services (groups, individual sessions, and family sessions) are being delivered. Therapists also turn in progress notes to the DMHCA daily for review.

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.*	

Five youth records were reviewed for treatment planning. Each of the reviewed youth records contained an initial mental health and substance abuse treatment plan. The initial mental health and substance abuse treatment plans were site-specific, which included all of the information on the Department's form MHSA 015. Each youth had an initial mental health and substance abuse treatment plan developed within seven days of admission. All five initial treatment plans were completed by a non-licensed mental health clinical staff and subsequently reviewed and signed

by the licensed clinical supervisor within ten days of completion. Each of the initial treatment plans were signed by treatment team members who participated in the development of the plan.

Five youth records were reviewed for completion of an individualized treatment plan and reviews. Each of the youth records contained an individualized treatment plan, which was developed within thirty days of the youth's admission. The five individualized treatment plans reviewed were developed on a site-specific form, which contained all of the necessary information on the Department's form MHSA 016. Each of the individualized treatment plans were completed by a non-licensed mental health clinical staff and were reviewed and signed by the program's licensed clinical supervisor within ten days of completion.

Four of the five of the individualized treatment plans were signed by treatment team members who participated in development of the plan, along with the youth, and parent/guardian, when available. The remaining individualized treatment plan was only missing the psychiatrist signature. This one youth was prescribed psychotropic medication after admission, which required the involvement of the psychiatrist. Review of the youth record revealed the psychiatrist was involved in the development of the individualized treatment plan but didn't sign the plan. Three of the five individualized treatment plans reviewed were applicable for the inclusion of psychiatric services, to include psychotropic medication and frequency monitoring by the psychiatrist. Each of these three youth's individualized treatment plans reflected the required review and monitoring for psychiatric services. Twenty-two individualized treatment plan reviews were conducted; for all five youth records reviewed. Each of the treatment plan reviews conducted were documented on a site-specific form, which included the information contained within the Department's form MHSA 017. Each of the individualized treatment plans documented the on-going prescribed services; individual, group, family, and/or psychiatric services, as needed.

Three youth records were reviewed for discharge plans. Each of the three discharge plans were documented on Department form MHSA 011 (Mental Health and Substance Abuse Treatment Discharge Summary). None of the youth required any type of notification for suicide risk or precautions. Each of the mental health and substance treatment discharge summaries documented the services required for daily maintenance of positive improvement in behavioral, emotional, and social skills made by youth during treatment. All three discharge plans contained documentation of the discharge plans having been discussed with the youth, parent/guardian, and juvenile probation officer (JPO) during the exit conference. A copy of the mental health and substance abuse treatment discharge summaries were provided to the youth, JPOs, and parents/guardians in each of the three youth records reviewed.

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, with positive tests followed by appropriate clinical intervention and sanctions. 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. Substance abuse groups offered do not exceed fifteen youth. Each youth receives daily therapeutic activities, which are provided by the

program's recreational therapist. A review of sign-in log reveals a psychiatrist is on-site, bi-weekly to provide psychiatric evaluations and 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 October 26, 2019. The program has a substance abuse clinical staff on-site seven days a week. Counselor caseloads for substance abuse treatment overlay services do not exceed sixteen youth. An interview with the program director revealed the program offers substance abuse overlay services.

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.	

The program has an agreement with a psychiatrist, who has completed a psychiatry program approved by the by the American Board of Psychiatry and Neurology, licensed under chapter 459, Florida Statute, and meets all requirements outlined with Florida Administrative Code 63N-1. The psychiatrist's license is clear and active, verified through Florida Department of Health (DOH), and expires January 31, 2020. A copy of the contract between Sequel and the psychiatrist was available for review while on-site. The program does not have a psychiatric advanced registered nurse practitioner (ARNP). The psychiatrist is on-site every two-weeks and is available to evaluate and monitor youth, as needed. Each youth prescribed psychotropic medication, receives psychotropic medication monitoring and review at a minimum of every thirty days. The psychiatrist is available for on call and emergency consultation twenty-four hours a day, seven days a week. The psychiatrist provides a briefing to a representative of the treatment team on the psychiatric status of each youth receiving psychiatric services who is scheduled for a treatment team review. The briefing is accomplished either through face-to-face interaction or telephonic communication with a representative or treatment team. The psychiatrist's evaluation and recommendations for the youth is incorporated into the mental health clinical staff's evaluations of the youth and the youth's individualized mental health or substance abuse treatment plan, as noted within the three applicable youth records reviewed. A review of the program's psychiatric log (sign-in/out log) for the psychiatrist, confirms his visits during the past six months, validating he was on-site every two-weeks. The psychiatrist is ultimately responsible for the prescription and monitoring of psychotropic medications at the program. A review of youth records revealed the psychiatrist actively participates in, manages, and supervises psychotropic medication service within the program. There were no indications of the program having any standing orders for psychotropic medications. In addition, there were no indications of any emergency treatment orders for psychotropic medications.

Five youth records were reviewed for psychiatric services. Each of the youth records reviewed were applicable for referral of psychiatric services. All youth referred were seen within fourteen days of the referral. Each of the initial diagnostic psychiatric interviews included a youth history, mental status examination, a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5), treatment recommendations (if applicable), prescribed medications (if applicable), explanation of the need for psychotropic medication, and frequency of medication monitoring. All five initial diagnostic interviews with the psychiatrist were documented on the Clinical Psychotropic Progress Note (CPPN) and clearly identified as "initial diagnostic psychiatric interview." Two of the five initial psychiatric diagnostic interviews resulted

in the prescription of psychotropic medication or changes to youth's existing psychotropic medication regimen. Page three of the CPPN was utilized in order to document the psychiatric interview. One youth who was originally seen by the psychiatrist, was later referred, and subsequently placed on psychotropic medications. Three youth were taking psychotropic medications. All three youth on prescribed psychotropic medication were seen for medication monitoring review by the psychiatrist every thirty-days.

An interview with the psychiatrist confirmed his role at the program is to evaluate new admissions and coordinate care with the team. He meets with the program's designated mental health clinician authority (DMHCA) and program director to discuss youth receiving psychiatric services while on-site and is also on-call should healthcare staff need to review important medical issues pertaining to the youth at the program receiving psychiatric services. In addition, the psychiatrist states he is available to conduct face-to-face or telephonic communication with a representative from the treatment team. The psychiatrist does not have any concerns with the health care at the program.

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 written suicide prevention plan which details suicide prevention procedures. The program's written suicide prevention plan, includes identification and assessment of youth at risk of suicide, staff training (total of six hours annually, to include mock drills for all staff), suicide precautions, levels of supervision (one-to-one, constant, and close supervision), referral, communication, notification, documentation, immediate staff response, and a review process. The program's written suicide prevention plan is reviewed annually. The last date the plan was reviewed and signed by the designated mental health clinician authority (DMHCA) and program director was on October 1, 2018.

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 written policies and procedures which specifically address practices for suicide prevention services. Part of the program's written procedures, outline practices to notify the juvenile probation officer (JPO) and parent/guardian of the youth's potential suicide risk, as indicated by an Assessment of Suicide Risk (ASR). The program's written policy and procedures outlines those practices necessary for a youth on precautionary observation (PO); whereas, at no time will a youth who is on PO be placed within a locked, secure room. There is

no indication the program has had any youth placed in secure observation during the annual compliance review period.

Five youth records were reviewed for suicide prevention services. Each youth reviewed had an ASR conducted upon admission to the program. Pursuant to the program's written suicide prevention plan; all youth admitted are assessed with a suicide risk assessment. All five youth, upon admission, were placed on PO. An ASR referral was made for each youth. Each youth had an ASR completed within twenty-four hours, using the required Department form, MHSA 004. Each youth was screened and subsequently placed on standard supervision. Suicide PO logs were completed for all five youth reviewed; documented on Department form MHSA 006. Each PO was authorized and mental health staff provided supportive services, as needed. In each of the five reviewed youth records, a conference between the licensed mental health professional and program director was documented in order to reduce the level of supervision. Four of the five ASRs conducted were completed by a non-licensed mental health clinical staff and subsequently reviewed by the program's licensed mental health professional (LMHP). The remaining ASR completed was conducted by the program's LMHP. Any youth on PO is allowed to participate in select activities with other youth in designated safe housing areas of the program. Youth on PO were not limited to an individual cell or restricted to her sleeping room. None of the youth assessed were determined to be in crisis. None of the ASRs were conducted outside of the program. A review of the programs log book and shift debriefing revealed instructions pertaining to those youth placed on suicide precautions.

The program has two suicide response kits on-site. Each of the suicide response kits contained a knife-for-life, wire cutters, and needle nose pliers. One suicide response kit was located within master control (front office) and the other located within the medical office. The program's written suicide prevention plan, written mental health crisis intervention plan, and written emergency mental health and substance abuse services plan, assist in addresses the program director's review process for every serious suicide attempt or serious self-inflicted injury. A multidisciplinary review includes, circumstances surrounding the event, facility procedures relevant to the incident, training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures.

Five staff were interviewed and responded they would notify mental health staff should a youth express suicidal thoughts. All five staff were able to identify the locations of the program's suicide response kits.

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.	

Five precautionary observation (PO) logs from the five youth records were reviewed. All five PO logs were documented on the Department's form MHSA 006 and were maintained for the duration the youth was on suicide precautions. Each of the PO logs documented the appropriate level of supervision and observations of the youth's behavior. Staff recorded observations of youth behaviors in real time, at a minimum of thirty-minute intervals. There were no noted or need to document warning signs in any of the PO logs reviewed. Each PO log was reviewed

and signed by each shift supervisor. All of the PO logs were reviewed and signed off by the mental health clinical staff. Each of the PO logs had supervisory reviews conducted. Three out of five PO logs included specific language documenting safe housing areas within the program. Two of the five PO logs reviewed were missing documentation of safe housing areas.

Five youth who had previously been on suicide precautions reported staff were with them at all times and were never left alone.

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

Six staff training records were reviewed for suicide prevention training; five pre-service and one in-service. Each of the five pre-service staff completed suicide prevention training. The remaining in-service staff did not complete any suicide prevention training. The program has a written suicide prevention plan, which includes suicide prevention training (to include mock suicide drills) for all staff to participate. The program has two operating shifts; shift A: 600 a.m. to 6:00 p.m., and shift B: 6:00 p.m. to 6:00 a.m. The program conducted one mock suicide drill on each shift during the first quarter. The program completed two mock suicide drills on the first shift and one for the second during the second quarter. Two mock suicide drills were completed on each shift during the third quarter. All of the reviewed mock suicide drills included action to be taken by staff; a method for contacting other program staff by radio or for back-up support to include emergency medical services 9-1-1. In addition, each mock suicide drill included life saving measures such as cardiopulmonary resuscitation (CPR) and/or the use of the suicide response kit. Forty-three of forty-six staff with direct contact, on a day-to-day basis with youth, participated in at least one quarterly mock drill semi-annually. Three staff did not participate in a mock drill at least quarterly; one staff was a pro re nata (PRN) youth care worker, and two other staff were teachers. Documentation of each drill is done utilizing a program specific form. The program has a process in place which allows staff not present during a mock drill to review each drill scenario and procedures.

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 written mental health crisis intervention services plan. The written mental health crisis intervention services plan includes a notification and alert system, means of referral (including youth self-referral), communication, supervision (one-to-one, constant, and standard supervision), documentation, and review process. The written mental health crisis intervention services plan was last reviewed and signed by the designated mental health clinician authority (DMHCA) and program director on October 1, 2018.

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.	

Three crisis assessments were reviewed. Each assessment was completed on Department form MHSA 023. Each crisis assessment documented the date the youth was determined to be in crisis, reason for assessment, a mental status examination and interview, determination of danger to self and/or others, initial clinical impressions, supervision recommendations, treatment recommendations, recommendations for follow-up or further evaluation, and notification to parent/guardian. During the crisis assessments, it was determined the youth were not in crisis and remained on standard supervision, therefore no mental health alerts were needed to be entered into the Department's Juvenile Justice Information System (JJIS). All three crisis assessments were completed by a non-licensed mental health clinical staff and were subsequently reviewed by the program's licensed mental health professional on the same date.

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 written emergency mental health and substance abuse services plan. The written emergency mental health and substance abuse services plan includes immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health services or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394, Florida Statute (Baker Act), transport for emergency substance abuse assessment and treatment under Chapter 397, Florida Statute (Marchman Act), documentation, training, and review process. The written emergency mental health and substance abuse services plan was last reviewed and signed by the designated mental health clinician authority (DMHCA) and program director on October 1, 2018.

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.	

Three youth records were reviewed for completion of Baker act referral, whereas, each youth was believed to be in imminent danger to themselves or others due to mental illness requiring emergency mental health stabilization services. Each of the three Baker Acts reviewed indicated how and when the youth was determined to be in need of emergency care. Each Baker Act

reviewed noted staff response to each specific incident and when a notification was made and by whom. Each of the three youth were placed on one-to-one supervision at the time of discovery. For all three records reviewed, mental health staff were involved. Each of the three youth were taken out of the program for Baker Act services. Transports for the youth to the receiving Baker Act facility were authorized. Upon return to the program, each youth was placed on constant supervision. A mental health referral was completed, indicating a mental status examination was to be conducted for each of the three youth. An Assessment of Suicide Risk (ASR) was completed by or under the direct supervision of a licensed mental health professional. Each of the youth were maintained on constant supervision until properly transitioned to a lower level of supervision. Each of the three youth's level of supervision was not lowered until the appropriate assessment was completed and the mental health staff conferred with the licensed mental health professional and the program director or designee.

Standard 4: Health Services

Overview

The program contracts with a medical doctor (MD) to serve as the designated health authority (DHA). The DHA has a specialty in family medicine. The DHA is available for contact twenty-four hours a day by phone and is on-site weekly. The DHA reviews medical records and the medical care provided, completes comprehensive physical assessments (CPA), monitors youth with chronic conditions, and assesses youth who have been referred by the nursing staff at the program. The program also contracts with a psychiatrist, who is responsible for psychiatric services, management of medications, and monitoring of youth's compliance with psychotropic medication regimens. The program employs two full-time registered nurses (RN), who provide coverage, on-site, seven days a week. The director of nursing (DON) is on call twenty-four hours a day, seven days a week. The DON is responsible for the operation of the clinic, which includes sick call, medication administration, referrals for off-site care, tracking and scheduling follow-up care, education, and training. The program has an active modified class II pharmacy permit. Prescriptions are faxed to the pharmacy vendor, PolarisRx, and medications are delivered to the program. The program has an arrangement with an optometrist to conduct vision exams on-site. Dental screenings and care are provided through a referral to the Alachua County Health Department (ACHD). Immunizations, sexually transmitted infection (STI) testing and treatment, and human immunodeficiency virus (HIV) testing are also provided by the ACHD.

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 designated health authority (DHA) is a licensed medical doctor who holds an unrestricted license and meets all requirements for independent and unsupervised practice in the State of Florida with a specialty in family medicine. The DHA has a contract with the program to provide medical services to the youth in the program. The DHA is on-site weekly and is on call twenty-four hours a day, seven days a week. A review of the sign-in log for the DHA found she was on-site each week for the past six months, with no more than nine days between visits. There was documentation indicating the DHA reviewed the medical documentation for all youth. The DHA signed and dated all medical policies and procedures. The licenses for both registered nurses (RNs) were current. In the event the DHA is on leave, a DHA from another program of the same provider provides coverage. An interview with the DHA confirmed her role in the coordination and implementation of health services at the program. The DHA performs comprehensive physical assessments, evaluates chronic conditions at least every three months, conducts sick call, and reviews and updates policy and procedures. The DHA confirmed she meets with the nursing staff weekly and the nursing staff maintains a running log of youth to be seen each week.

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.	

There is documentation an annual review of all health-related facility operating procedures (FOP) is completed by both the facility administrator (FA) and the designated health authority (DHA) annually. The last review was on December 6, 2018. The DHA signed and dated all respective treatment protocols. The nursing staff reviewed, signed, and dated a cover letter which stated they will follow treatment protocols. There are treatment protocols for nonhealthcare staff for use when a nurse is not available. The DHA has also reviewed established standing orders for each admission. There are no standing orders concerning psychotic medications. New employed healthcare personnel training includes documenting a review of Florida Administrative Code 63M-2, nursing protocols, and program facility operating procedures for health services.

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 healthcare records were reviewed for completed Authority for Evaluation and Treatment (AET) forms. In two records, a legible copy of the AET with the word “copy” stamped on it were found. One record had a court order filed in the healthcare record. Two records were not applicable, as the youth were eighteen years old. Copies of completed parent/guardian notifications are maintained behind the AET in the healthcare record.

4.04 Parental Notification	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 healthcare records were reviewed for parental notification. Three records were applicable, as two youth were eighteen years old. Two of the youth records required documentation of over-the-counter medications beyond those covered by the Authority for Evaluation and Treatment (AET). For new medications, verbal attempts were documented in the progress notes and written notifications are sent regardless of telephone notifications. There was documentation a staff member witnesses all telephone attempts and conversations. None of the youth records required a notification be sent for emergency care.

4.05 Notification – Clinical Psychotropic Progress Note	Satisfactory Compliance
The program shall inform the parent/guardian and obtain consent for the prescription of new psychotropic medications, discontinuances, or psychotropic medication adjustments.	

Three youth healthcare records were applicable for notification regarding the Clinical Psychotropic Progress Note (CPPN). All three youth records documented the CPPN was mailed for the initiation of psychotropic medication. Two applicable records had documentation notification was sent for significant changes or discontinuation of psychotropic medication. All three youth records had documentation of verbal consent being obtained for the CPPN. The telephone conversations were witnessed. Written notification was sent to the parent/guardian on the Department’s Acknowledgment of Receipt Form of CPPN.

4.06 Immunizations	Satisfactory Compliance
All youth's immunization history and status shall be verified to meet state and department requirements, and subsequently provide necessary immunizations/vaccinations (with parent/guardian consent).	

Five youth healthcare records were reviewed for immunizations. All five youth records had documentation the vaccinations were verified within thirty days of each youth's admission. In one of the youth records, the parent/guardian denied immunizations, claiming a religious exemption. There was no Religious Exemption from Immunization Form filed in the youth record. An interview with the director of nursing confirmed immunization records are reviewed for each youth at the time of admission.

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

Five youth healthcare records were reviewed for the Facility Entry Physical Health Screening form (FEPHS). There was documentation in all five records the FEPHS forms were completed on the date of each youth's admission. In two youth records, direct care staff completed the form with documentation the registered nurse (RN) reviewed the form within twenty-four hours. In three youth records, the FEPHS form was completed by a RN.

4.08 Medical Alerts	Satisfactory Compliance
Staff shall be alerted of medical issues that may affect the security and safety of the youth in the facility.	

Five youth healthcare records were reviewed for medical alerts. There was documentation in the youth records the medical alerts were confirmed by a registered nurse and entered into the Department's Juvenile Justice Information System (JJIS). All five youth had a medical grade of four or five. The youth on psychotropic medications were documented on the internal alert list and in JJIS, with some delay. One youth had a start date of June 7, 2018 for psychotropic medication with the JJIS alert not entered until October 5, 2018, four months late. One youth had a start date of July 11, 2018 for psychotropic medication with the JJIS alert not entered until October 26, 2018, over three months late. One youth had a start date of September 12, 2018 for psychotropic medication with the JJIS alert not entered until October 26, 2018, six weeks late. The internal alerts matched the JJIS alert list, with no exceptions. The issue with alerts was identified and brought to the attention of the program in October 2018. Since then, the program has implemented new procedures to correct this issue.

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

The program has a policy and procedures regarding youth orientation to healthcare services to be completed within twenty-four hours of admission. Five youth healthcare records were reviewed. In all five youth records, there was documentation the youth received healthcare orientation within twenty-four hours of admission to the program. The healthcare orientation topics include how to access sick call, what constitutes an emergency, how medications are

administered, when to notify staff for side effects, allergies, medical issues, and chest pain or shortness of breath after exercising. Orientation also included the right to refuse care, what to do in the case of a sexual assault, the non-disciplinary role of the healthcare provider, and when healthcare staff have to notify program administration.

4.10 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 healthcare records were reviewed, of which two were applicable for notification to the designated health authority (DHA) concerning a chronic condition. Both records documented the DHA was notified by telephone. Each notification was documented in the youth intake progress note. None of the youth were identified as in-need of an emergency response. The program's procedures is to inform the DHA of all youth admissions to the program without exceptions. There was documentation in each youth record indicating the DHA was notified of the youth's admission.

4.11 Healthcare Admission Rescreening	Satisfactory Compliance
A Healthcare Admission Rescreening shall be completed each time the physical custody of the youth changes and they are subsequently returned or readmitted to the facility.	

Three applicable youth healthcare records were reviewed for a healthcare admission rescreening. All three youth had a Facility Entry Physical Health Screening (FEPHS) form completed by a registered nurse upon the youth's return to the program, on the same date of the youth's return.

4.12 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 healthcare records were reviewed, and each youth record contained a new health related history (HRH), completed on the date of admission to the program. Each HRH was documented on the Department's Health Related History form (HS014) by a registered nurse and reviewed by the designated health authority (DHA) on their next site visit. All of the HRH forms were completed before, or at the same time as, the comprehensive physical assessment (CPA).

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

Five youth healthcare records were reviewed, and each had a new comprehensive physical assessment (CPA) which was completed using the Department's form (HS017). All five youth records had a current CPA completed by the designated health authority (DHA) within seven days of admission. All sections of the CPA were addressed. For the three youth refusing a section of the examination, it was noted the youth refused and signed. Each youth had a

medical grade documented. The Department's Problem List was updated, as needed, for the four applicable youth.

4.14 Female-Specific Screening/Examination	Satisfactory Compliance
All adolescent girls shall receive gender-appropriate screenings, examinations, and tests to address their unique needs.	

Five youth records were reviewed and each had documentation showing the youth had a qualitative urine pregnancy test at the time of admission. Each youth had signed consent for the pregnancy test. One youth record indicated the youth had the test September 7, 2018 but did not sign consent until December 9, 2018. However, the youth provided the urine sample for the pregnancy test, indicating implied consent. Two of the five youth gave verbal consent for a gynecological examination. The other three youth refused a gynecological examination.

4.15 Tuberculosis Screening	Satisfactory Compliance
All youth shall be screened for Tuberculosis, and accurate documentation of results shall be maintained by each facility.	

The program has a policy and procedures regarding tuberculosis screenings. All five reviewed youth records had documentation of a tuberculin skin test (TST) completed within the last year. In each youth record, the TB screenings were documented on the comprehensive physical assessment (CPA) and the Infectious and Communicable Diseases (ICD) form. In each youth record, the Tier I TB screening was completed on the Facility Entry Physical Health Screening form.

4.16 Sexually Transmitted Infection Screening	Satisfactory Compliance
The program shall ensure all youth are evaluated and treated (if necessary) for sexually transmitted infections (STIs).	

Five youth healthcare records were reviewed. A sexually transmitted infection (STI) screening was completed by the registered nurse on the day of admission in each record. Each STI screening was reviewed by the designated health authority (DHA) within seven days of admission. Testing was ordered for four of the five youth. Each of the four youth had the testing completed and the results documented on the Infectious and Communicable Diseases (ICD) form. The referrals for testing were documented on the STI screening form. The lab results were field in each youth's healthcare record.

4.17 HIV Testing	Satisfactory Compliance
The program shall routinely offer counseling, testing, and referrals for medical treatment to all youth at risk for HIV infection.	

Five youth healthcare records were reviewed, and each had documentation the youth was offered human immunodeficiency virus (HIV) testing. Four of the five youth consented for a HIV test. Pre- and post-test counseling was completed by Alachua County Health Department certified HIV counselor with 501 certification from the Department of Health. Documentation of the pre- and post-test counseling was documented on the Individual Health Education Record for each youth. Each youth's HIV results were in a sealed envelope, marked confidential, in each healthcare record. Five youth were interviewed and all stated they could ask for a HIV test.

4.18 Sick Call Process – Requests/Complaints	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.	

Sick call is scheduled twice a day and is conducted by a registered nurse. When a licensed nurse is not on-site, trained staff utilize “Report of on-site health care by non-healthcare staff” form. The designated health authority has approved protocols in place in the absence of a medical professional. The form is forwarded to the nurse for follow-up the next day. Five youth healthcare records were reviewed with none presenting with a similar sick call complaint three or more times within a two-week period. No youth presented with a complaint of severe pain which staff were not familiar. The completed sick call request forms were filed with the progress notes in youth healthcare record, in reverse chronological order. Five youth were interviewed with two youth stating they could see the nurse immediately and three stating they could see the nurse within one day.

4.19 Sick Call Process – Visits/Encounters	Satisfactory Compliance
The facility shall respond appropriately, in a timely manner, and document all Sick Call encounters, as required by the Department.	

Five youth healthcare records were reviewed for sick calls. Four of the five youth had a total of seventeen sick call encounters. Each of those encounters were documented on the respective youth sick call index and on the program’s sick call referral log. Sick calls were documented in each youth’s progress notes in the youth healthcare record. Each sick call form had documentation of the youth’s signature or initials indicating the youth was seen with one exception. The sick call forms were filed in the youth’s record in reverse chronological order. Five staff were interviewed and all five staff stated sick call is conducted by a registered nurse. The sick call process was not available to be observed during the week of the annual compliance review.

4.20 Restricted Housing	Non-Applicable
All youth in Room Restriction/Controlled Observation s shall have timely access to medical care, as required by the Department.	

The program’s policy, procedure, or contract states they do not use restricted housing; therefore, this indicator rates as non-applicable.

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

The program has an episodic and emergency care policy and procedures. The five reviewed youth healthcare records had a total of fifteen episodic care encounters. One of the encounters required a referral for off-site care. All episodic care encounters reviewed were conducted by a registered nurse and documented using problem-oriented (subjective, observation, assessment, and plan) SOAP elements. All incidents of episodic care were documented on the log. The program has seven first aid kits in the program with two additional first aid kits for the transportation vans. The designated health authority has signed off the items required in the first aid kits. Three first aid kits were opened and checked for contents. One first aid kit was missing

burn spray even though the sealed kit noted it as being there. Five youth were interviewed. Three youth stated they could see a dentist, if needed, for tooth pain and two stated they could not. All five youth stated they could see a doctor, if needed.

4.22 Emergency Care	**Satisfactory Compliance**
The facility shall have established processes and procedures for either directly providing Emergency Care or facilitating an appropriate response to an emergency situation.	

The program has a policy and procedures regarding emergency care. The program has one Automated External Defibrillator (AED) which is kept in the area designated as master control. The instruction guide is attached to the AED. The AED batteries and pads are checked weekly by a registered nurse. The AED batteries were checked and noted to expire December 2023; the batteries were changed in May 2018. The AED pads were checked and noted to expire December 2019; the pads were changed in August 2017. The registered nurse conducted a test on the AED which indicated it was in working condition. Mock emergency medical drills were done monthly, exceeding the requirement of quarterly drills. Cardiopulmonary resuscitation (CPR) and AED are demonstrated at least once a quarter. Drills are discussed at the next all staff meeting for staff not present during the medical drill. A list of emergency numbers is maintained by master control and in the medical clinic. There was documentation supervisory staff were trained in the use of an EpiPen auto injector. Five staff were interviewed and all five stated they are personally allowed to call 9-1-1 if a youth has a medical emergency.

4.23 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 healthcare records were reviewed for off-site care, with two youth having six off-site care events, three for each youth. Both youth were eighteen years old and did not require parent/guardian notifications. One youth had the Summary of Off-Site Care form utilized for one of the off-site events. There was documentation the designated health authority (DHA) signed the form and it was filed along with discharge documents. For the other five off-site events, the Summary of Off-Site Care form was not completed by the community provider. The DHA initialed the last page of all discharge documents, indicating her review of the documents. Both youth received timely follow-up care, as needed.

4.24 Chronic Illness/Periodic Evaluations	**Satisfactory Compliance**
The facility shall ensure youth who have chronic illnesses receive regularly scheduled evaluations and necessary follow-up.	

Three of the five youth reviewed had chronic conditions. For two of the youth, the DHA was notified at admission concerning the chronic condition. The third youth was identified as having a chronic condition subsequent to admission. All three youth were seen monthly by the DHA. Each of the three youth have prescription medication renewed prior to the medication expiring. Treatment orders were written clearly, distinguishable for clinical staff. In each record, the Department's Problem List was updated, as needed. An interview with the DHA confirmed periodic evaluations for youth with chronic conditions are conducted at least every three months and the nursing staff maintain a log when youth are due for periodic evaluations.

4.25 Medication Management – Verification	Satisfactory Compliance
A youth's medication regimen shall be ascertained upon admission to the facility.	

Three applicable youth healthcare records were reviewed for youth entering the program with prescribed medication. Each youth was received from another Department facility. All three youth records had documentation indicating the medication was verified. Each of the records had a list of medications the youth was taking at the time of admission. Each youth record had documentation the designated health authority and or psychiatrist was contacted to resume the specified medications. Each youth's Facility Entry Physical Health Screening form documented the youth was admitted with medication requiring subsequent verification.

4.26 Medication Management – Orders/Prescriptions	Satisfactory Compliance
All medications shall have a current, valid order and are given pursuant to a current prescription or Practitioner Order.	

Five youth healthcare records were reviewed for medication management. Valid medication orders were in place for each prescription medication and over-the-counter (OTC) medication to be taken on a regular basis. Standing orders for OTC medications were also signed by the designated health authority (DHA). All medications had a current, valid order and were given pursuant to a current prescription. For OTC medications administered which were not on the Authority for Evaluation and Treatment, notifications were mailed to parent/guardian. There was documentation medication is administered based on the DHA order.

4.27 Medication Management – Storage	Satisfactory Compliance
All medications (e.g., prescriptions, over-the-counter, topical) are stored in separate, secure (locked) areas inaccessible to youth.	

All medications were observed to be secured in areas inaccessible to youth. All non-controlled medications are stored in a separate, secure, locked area inaccessible to youth. Controlled medications are stored behind two locks. Oral medications are not stored with injectable or topical medications. There is a refrigerator in the clinic designated for medication requiring refrigeration. During the annual compliance review period, there was no medication requiring refrigeration and there were only ice packs kept in the refrigerator. Sharps are stored in secured cabinets in the clinic. The medication cart is clean, organized, and stock items are separate from youth-specific medications. The program's policy is to return medications to the pharmacy for disposal and destruction.

4.28 Medication Management – Medication and Sharps Inventory	Satisfactory Compliance
All medications and sharps shall be inventoried as per department requirements.	

All over-the-counter (OTC) medications are maintained through a perpetual inventory and inventoried at least weekly. Perpetual inventory with running balances were maintained on all controlled substances with a shift-to-shift inventory. Sharps also use a perpetual inventory which were counted whenever used and at least weekly. The program's policy and procedures requires the disposal of controlled substances to be done in the presence of the pharmacy representative and two registered nurses. There were three randomly selected sharps counted

and compared to their written inventory, with no discrepancies. There were three randomly selected youth medications counted and compared to their written inventory, with no discrepancies. There were three randomly selected bulk over-the-counter medications counted and compared to their written inventory, with no discrepancies. A review of inventory documentation for the past six months confirmed the program's practice of weekly inventory being conducted.

4.29 Medication Management – Controlled Medications	Satisfactory Compliance
All controlled substances shall be inventoried, stored, and documented, as per Board of Pharmacy and Department requirements.	

The program has a written policy and procedures regarding controlled medication inventory. The policy includes the nursing shift-to-nursing shift inventory. The program's policy requires the shift-to-shift count to be documented by a shift supervisor or program administrator. There were only two controlled medications on-site during the annual compliance review. The physical inventory matched the documented inventory. Inventory documentation for the two youth since their arrival was reviewed with no discrepancies.

4.30 Medication Management – Medication Administration Record	Satisfactory Compliance
The standard Department Medication Administration Record (MAR) shall be maintained at the facility for each youth who has a current, valid medication order.	

Five youth healthcare records were reviewed, and all five youth had a current Medication Administration Record (MAR). The program uses the standard Department MAR. The MAR contained all elements required, including the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade, medical alerts, and a current picture of youth which is kept in the MAR book with the active MARs. Nursing staff documented the monitoring of side effects daily. For youth taking medication at admission, the initial MAR matched the medication list. Staff initial each administered medication entry along with the youth. There were no lapses in medication administration. At a minimum, the nursing staff documented weekly side effect monitoring on the MAR.

4.31 Medication Management – Medication Administration by Licensed Staff	Satisfactory Compliance
Medication Administration shall occur as scheduled in a comprehensive, accurate, and organized manner in the facility, only by a licensed nurse.	

Medication administration was observed and occurred, as scheduled. Medication delivery and supervision was the sole responsibility of the nurse during the time of administration. The working space was clean and organized, the nurse had control of the medications, and there was a structured process for the youth to approach the nurse. The youth were escorted one at a time to medication pass. The Five Rights of Medication Administration were verified for each youth. The nurse asked about any side effects with each youth. Staff observed to ensure the medication was swallowed. Five youth were interviewed and all five stated the nurse gives youth their medication. Five staff were interviewed and all five stated the nurse gives youth their medication. Two staff also stated a trained staff can give a youth medication.

4.32 Medication Management – Medication Provided by Non-Licensed Staff	Satisfactory Compliance
Trained, non-health care staff may assist youth with self-administration of oral prescription medications or over-the-counter medications, only when licensed nurses are not available on site. The nurse shall delegate the delivery, supervision, and oversight of youth during self-administration of medications.	

The program has a policy and procedures for medication administration when there is not a nurse is on-site. Designated non-healthcare staff, supervisory staff, are permitted to assist in the delivery of oral medication, prescribed, and over-the-counter medications, in the absence of a licensed healthcare professional. There were no recent examples of non-healthcare staff assisting with the administration of medications. Non-healthcare staff are trained by the director of nursing.

4.33 Medication Management – Psychotropic Medication Monitoring	Satisfactory Compliance
The facility shall have a comprehensive process in place for the monitoring of psychotropic medications, to ensure youths' safety, as required by the Department.	

Three youth healthcare records were reviewed for youth who were prescribed psychotropic medications while at the program. Two of the three youth were on psychotropic medications when admitted to the program. For those two youth, there was documentation indicating the designated health authority (DHA) and psychiatrist were notified upon the youth's admission. For the two youth, the psychotropic medications were discontinued or put on hold pending the initial diagnostic psychiatric interview. Each initial diagnostic psychiatric interview was conducted within fourteen days of the youth's admission into the program. The psychiatric evaluation was documented on the Department's Clinical Psychotropic Progress Note (CPPN) with all three pages. All three youth were placed on psychotropic medication subsequent to their admission. Each youth had a monthly CPPN continuing the youth on the psychotropic medication. There are no standing orders for psychotropic medications or emergency treatment orders for psychotropic medications.

4.34 Infection Control – Surveillance, Screening, and Management	Satisfactory Compliance
The facility 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 program has a policy and procedures in place for infection control to utilize all available interventions to prevent and minimize the spread of disease among youth and staff. The plan includes the following types or categories of diseases: common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, Hepatitis A, B, and C and HIV infectious diseases caused by blood-borne pathogens, other outbreaks or epidemics caused by any other infectious agent, whether spread directly or indirectly, outbreaks of pediculosis (lice) and/or scabies, Methicillin-Resistant Staphylococcus Aureus (MRSA) and other emerging antibiotic-resistant micro-organisms, bloodborne illnesses such as those cause by Escherichia coli, bio-terrorist agents such as anthrax and small pox, and chemical exposures in the workplace. Universal precautions are included in the comprehensive education and prevention plan at the program. Hepatitis B immunizations are available to staff, if necessary, at no cost. Staff have access to protective

equipment. There were no instances in which the local county health department and/or the Centers for Disease Control and Prevention (CDC) were required to be notified.

4.35 Infection Control – Education	**Satisfactory Compliance**
The facility's comprehensive Infection Control education plan shall include pre-service and in-service training for all staff, and youth infection control education, as per Centers for Disease Control and Prevention (CDC) guidelines.	

Five pre-service staff training records were reviewed. Each record had documentation of infection control training. One in-service staff record was reviewed with no documentation of infection control training. The director of nursing maintains training sign-in sheets and had documentation of in-service training to staff for infection control and exposure control plan twice a year.

4.36 Infection Control – Exposure Control Plan	**Satisfactory Compliance**
The facility's exposure control plan shall meet the requirements of OSHA standards (29 CFR 1910), with maintenance and documentation of the plan, as per the requirements of the Department.	

The program has a policy and procedures in place for exposure control plan. The plan is maintained in the master control area and available to all staff. The plan is reviewed and signed annually by the facility administrator and designated health authority. The plan includes risk assessment, methods of compliance, and a comprehensive process in place for needle stick post-exposure evaluation. The program has not had any incidents requiring them notifying the local county health department or the Centers for Disease Control and Prevention (CDC).

4.37 Prenatal Care – Physical Care of Pregnant Youth	**Satisfactory Compliance**
The facility shall provide prenatal care at recommended intervals. High-risk pregnant youth shall be provided additional testing and services as recommended.	

Three youth healthcare records were reviewed for pregnant youth. Two of the pregnant youth had been at the program for over thirty days each. Both of those youth had documentation of prenatal care since admission to include monthly visits with an obstetrician gynecologist and the designated health authority (DHA). One pregnant youth arrived at the program within the last seven days and had only met with the DHA. She was scheduled to see an obstetrician gynecologist next week. Each of the three youth are prescribed and taking prenatal vitamins daily. Five youth were interviewed. Four of the youth stated they have received prenatal, obstetrical, or gynecological services since being in the program.

4.38 Prenatal and Neonatal Care – Nutrition, Education of Youth, and Lactation	Satisfactory Compliance
The facility shall provide nutritious foods in sufficient quantities meeting the standards of the minimum daily allowances for pregnant youth. Each pregnant adolescent shall receive prenatal, post-partum, and parenting education including topics directly related to health care issues and medical risk for pregnant adolescents. *The program provides education to pregnant and postpartum girls about infant care and lactation.*	

Three youth healthcare records were reviewed for pregnant youth. There is documentation the director of nursing met with the youth weekly for education on prenatal care and education of youth.

4.39 Prenatal and Neonatal Staff Education	Limited Compliance
All non-healthcare staff involved in the supervision or treatment of pregnant youth and their infants must receive appropriate education.	

The program currently has three pregnant youth. There is no formal documentation of training provided to staff for the monitoring, observation, and emergency care of pregnant youth prior to the annual compliance review. There is documentation of informal minutes from an all staff meeting where the director of nursing provided education on symptoms to watch for with pregnant youth. The staff meeting occurred on the same day as the admission date of the first pregnant youth arriving at the program. Prior to the end of the review, the program provided documentation the director of nursing had conducted training on pregnancy education and monitoring, observing, and emergency care of pregnant youth with all staff, over two training sessions. A total of twenty-four staff were trained between the two training sessions.

Standard 5: Safety and Security

Overview

Direct care staff are responsible for supervising youth, conducting searches, and application of the behavior management system. Youth counts are conducted formally and informally throughout the day and documented in the facility log book. The program has sixteen cameras which record the activities of the program and store at least thirty days of activities for review. The program has added a master control position which operates from 6:00 a.m. to 6:00 p.m. Master control is responsible for maintaining the log book, calling for formal counts, issuing keys, and searching anyone prior to their entry to the secure floor. Shift supervisors are responsible for these functions when master control is not present.

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

The program has a policy and procedures in place to ensure youth supervision is followed. During the annual compliance review, staff were observed interacting with the youth in a positive manner. Staff to youth ratios were followed (1:8 during awake hours and 1:10 during sleeping hours). The program has the daily schedule posted through the living areas and sleeping areas. A review of the log books indicated staff conduct counts after each movement and at the beginning of each shift. Logbook entries indicated counts were also conducted after fire drills, emergency drills, or escape drills. Daily observations of staff interaction and youth movement during lunch, outside recreation, and class movement were also made. During observations, positive interactions between staff and youth, youth engaged in a full schedule of activities, consistent application of the behavior management system, and close monitoring of youth behavior and changes in behavior were observed. Staff searched youth when they moved from one location to another and counts were conducted. Staff were asked the number of youth they were supervising during various times of the review to verify ratio. Staff immediately knew the count. Staff were asked to explain the procedure if the count is not reconciled. They explained youth movement is stopped and a physical count is conducted by the supervisor.

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) employed at the program.*	

The program has a policy and procedures for the behavior management system (BMS). A review of five youth case management records indicated the youth orientation and hand book included a review of the program’s BMS. Rules governing the conduct of positive and negative

consequences for behavior are posted or are in the handbook. The BMS does not allow room restrictions or youth to punish other youth. The BMS does not allow group punishment, confinement, or denial of the youth's basic rights. All five interviewed staff understood how the BMS should be implemented, the point system used by the program, and could explain what type of rewards are given to youth. Five youth were interviewed, and each was able to explain the program's level system and how to progress to the next level.

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 director stated incident reports are reviewed by shift supervisors and given to the treatment team members. The shift supervisors monitor the behavior management system (BMS) and the staff to be sure it is used in a fair and consistent manner. Supervisors provide guidance to staff members and youth about the BMS and give feedback. Each of the five interviewed youth could explain how points could be taken and the consequences for losing points. Four of the five youth stated rewards are given when earned, one youth stated staff are not consistent with rewards. All five interviewed staff stated youth are informed at treatment teams why they have lost points and are given an opportunity to explain their behavior. Each of the staff stated they are given feedback about the BMS through briefings, meetings, and positive feedback from supervisors.

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.	

Written documentation and video footage of ten-minute checks of the youth in their rooms were reviewed for six separate dates, for a total of seventeen hours. There were no discrepancies in the video and documentation. The program conducts checks when youth are in their rooms at eight-minute intervals. All checks were documented in real time. Five staff were interviewed. Three responded checks are completed at ten-minute intervals, one responded eight minute intervals, and one responded room searches are conducted daily at night time room searches are not usually done. However, based on documentation checks are completed as required.

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 practicable 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 has a policy and procedures for conducting counts, tracking when a youth is moved from one location to another. Counts are conducted before every shift, during emergency drills, and after outside recreation. Documentation is placed in the master control logbook when medical, mental health, and other staff move a youth and back to the group. Five staff were interviewed and stated youth are counted every hour, between movements, and during emergencies. Counts were observed being conducted throughout the annual compliance review anytime youth movement occurred such as youth moving to classrooms, lunch, or restroom.

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.	

A review of the program's logbooks indicated they are maintained by the master control operator and the shift supervisor. All entries were made in ink with no erasures or whiteout. All entries included the date, time, staff names and signatures of the staff making the entry, and a description of the incident. Incoming staff sign and date the shift report for the previous shift he or she has reviewed or has been verbally briefed by the shift supervisor. Six shift reports were reviewed, all contained staffing, perimeter checks, youth counts, contraband searches, and other important information. All calls to the Florida Abuse Hotline or the CCC were documented.

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 has a policy and procedures for the control of the facility keys. Key assignment is logged by master control or a shift supervisor. All keys are secured in a locked cabinet. Staff are given numbered keys at the beginning of their shift and must turn in their personal keys. There are permanent keys assigned to the administrators and a log is kept of those keys. Visitors are required to turn in their keys when entering the facility and they are given a numbered chit for their keys. The maintenance mechanic, the assistant facility administrator, and a shift supervisor were interviewed and confirmed the process. Five additional staff were interviewed and all stated staff keys are given to master control upon entry, personal keys are securely stored, visitor personal keys are given to master control upon entry, there is daily tracking of keys, program keys are assigned to staff, and youth do not have access to keys. Additionally, all indicated if keys are missing master control would be notified, a facility search would be conducted, and for damaged keys the key is replaced. A random check of staff for personal keys was conducted and revealed they did not have their personal keys. The key inventory was reviewed and it matched the keys in use.

5.08 Contraband Procedure	Satisfactory Compliance
The program shall develop and implement a system to prevent the introduction of contraband into the program. *A residential commitment program shall delineate items and materials considered contraband when found in the possession of youth. 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 youth.* *The program shall document the confiscation of any 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.*	

The program has a policy and procedures defining what is considered contraband. A review of five youth records found all youth signed, indicating they received a resident handbook during admission, which includes what is considered contraband. The facility logbooks indicated the youth are searched throughout the day as they are moved to and from different locations or they leave the facility and return. There is a list of items deemed contraband which is posted in the

front lobby for visitation. Any item listed as contraband is documented and turned over to law enforcement if deemed illegal. There was no contraband found during the last six months.

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

The program has a policy and procedures addressing youth searches. A full body visual search is conducted by two staff who are the same sex as the youth being searched. An electronic search can also be used. Youth are pat searched after coming from outside the facility, before and after visitation, coming from educational and vocational activities, and outside recreation. Searches were observed throughout the annual compliance review and were found to be conducted in a respectful manner. Five staff were interviewed and stated youth are searched after any movement. Five youth were interviewed and stated they were searched after any movements, or if staff misplace their keys, after educational and vocational activities, and outside recreation.

5.10 Vehicles and Maintenance	Satisfactory Compliance
All vehicles transporting youth shall receive appropriate maintenance and contain safety and emergency equipment so they may be operated in a safe manner. *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 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 vans which are used to transport youth. All safety equipment was in each van including fire extinguisher, window punch, an approved first aid kit, and a seatbelt cutter. There were no youth transports during the annual compliance review. The maintenance mechanic has been filling in at this program for approximately two months, as the assigned maintenance mechanic is on administrative leave. A review of records from van YA695 dated June 21, 2018 indicated it was inspected and there were recommendations for a few minor repairs which were completed. A review of records for van 34522 dated September 30, 2018 indicated it was inspected and there were recommendations for repairs which were completed.

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

The program uses two vans for youth transportation which were found to be secured during the annual compliance review. One van does not have a partition between the youth and the driver. Staff indicated when youth are transported, two staff go on the transport. This same van can be opened from inside, at the rear side door; however, at the time of the annual compliance review, the rear doors would not open. Before the annual compliance review was completed, the maintenance mechanic fixed the side door from opening from the inside. A review of staff

assigned to transport youth found each have a valid driver's license. Five staff were interviewed and indicated a cell phone was provided during transport and personal vehicles were not used to transport youth.

5.12 Weekly Safety and Security Audits	Satisfactory Compliance
Appropriate minimum staff to youth staffing patterns shall be maintained while youth are transported off facility grounds to ensure the safety and security of youth, staff, and the public.	

The program has a policy and procedures to address safety and security issues. A safety and security audit was completed on a weekly basis and was conducted by upper management, the program director, assistant administrator, or program manager. Any issues are documented on the audit form and addressed timely. On September 26, 2018, camera one was not working, a vendor was called to make repairs. On October 30, 2018, a camera was brought for the program to use until the repairs could be made. On November 24, 2018, the vendor came out and replaced a fuse in camera one and it is now working.

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.	

The program has a policy and procedures for the access, issue, and inventory of the program's tools. The maintenance mechanic is responsible for the inventory, storage, and usage of the tools. Mops, brooms, and dust pans are the only tools in the program and they are kept in a laundry room. All other tools are kept outside the main building in a locked office which youth have no access. Kitchen sharps are kept in the kitchen in a locked box in the kitchen manager's locked office and inventoried every day or after they are used. Five youth were interviewed and stated they can use mops and scrub brushes only.

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

The program has a policy and procedures to address the usage of tools by the youth. Youth were not observed using any class A tools during the annual compliance review. A review of five youth case management records was completed and all youth were not allowed any cleaning duties at intake. At the time of the annual compliance review, all youth reviewed were allowed to use cleaning tools, mops, brooms, and dust pans. The assistant facility administrator stated youth are not allowed to work in the kitchen. Five staff were interviewed, and all staff indicated youth were only allowed to use mops, brooms, and scrub brushes.

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

The program has a policy and procedures to address outside contractors. The contractor will sign prior to entering a secure area and the maintenance mechanic will escort the contractor to the work area and stay until the work is completed. The maintenance mechanic will inventory

the tools the contractor brings in. There was only one contractor in the secure area during the last six months and reviewed documentation confirmed his tools were inventoried.

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 keeps their fire and escape drills in a binder in the program director's office. The program conducts monthly fire drills. Documentation of the drills contains the time it started and ended, date, staff involved in the drill, location, a narrative, and correction, if needed. The program conducted three escape drills, documenting all required information. The drills were completed as required. The program completed one Continuity of Operations Plan (COOP) drill dated October 8, 2018 and one emergency response procedures drill dated August 23, 2018. All five interviewed staff stated they participated in weather drills. One a major disturbance, one a bomb threat, one a hostage situation, and four flooding. Five youth were interviewed and all five knew what to do in case of a fire.

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.	

The program has a disaster and Continuity of Operations Plan (COOP) which was signed by the regional director on June 22, 2018. The COOP includes fire and fire prevention and evacuation, severe weather, disturbance or riots, bomb threats, hostage situations, chemical spills, flooding, terrorist threats or acts, staff roles and responsibilities, any equipment and supplies needed, alternative housing arrangements, provisions for continuity of care and custody of youth, and provisions for public protection. The COOP is kept in the master control room, easily accessible to staff. Provision of equipment and supplies required for continuous operation and services during emergency or disaster situations was also observed. The COOP location and availability to all staff was confirmed through an interview with the program director.

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

The flammable storage locker was observed located outside of the building. During a tour of the program, a red plastic gas container containing gas sitting on the flammable cabinet, and a box of Clorox bleach next to the flammable cabinet were observed. Both items were unsecure. The gas container was placed into the flammable cabinet and placed on the inventory as was the bleach. The assistant facility administrator stated youth have no access to the area of the flammable cabinet. A review of the flammable cabinet inventory revealed it contained six items, all of which were accounted for.

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 has a policy and procedures to address youth handling toxic, flammable, and poisonous materials. No youth are allowed to handle any toxic, flammable, or poisonous materials or have access to them. All items are kept in a locked storage area outside of the facility. The maintenance mechanic keeps an inventory of all items stored. The only staff authorized to remove these items are the program director, assistant facility administrator, lead supervisor, shift supervisor, and food service worker. Five youth were interviewed and two stated they are allowed to paint but the staff would pour the paint into the paint tray. Five youth indicated staff will spray window cleaner for them to clean the windows.

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

The program has a policy and procedures for disposal of all toxic, flammable, and poisonous items. According to the facility operating procedures, the safety and security officer, maintenance mechanic, will maintain an inventory of all flammable, toxic, and poisonous items used at the program. The kitchen manager stated the grease from the kitchen is disposed in an outside container and is picked up once a year. The program used an outside vendor to dispose of any toxic, flammable, or poisonous waste. Items identified as toxic, flammable, or poisonous may by drawn by authorized by the shift supervisor, administrator, and assistant administrator. No youth have access to any of these items.

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

The program's schedule and activities observed during this annual compliance review period indicated the youth are engaged in large muscle group exercises one hour a day. Youth were observed outside, participating in outside recreation. The program has a recreational therapist who meets all qualifications, as provided by the contract. Five youth were interviewed and all stated they participated in at least one hour of exercise per day. Youth participated in walking the recreation yard, Zumba, cardio together, and running. Therapeutic activities provided are incorporated into the youth's individualized performance/treatment plans.

5.22 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 water-related activities; therefore, this indicator rates as non-applicable.

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

The program has a policy and procedures for visitation and communication with family members. Youth are allowed to send mail to their parents/guardians. Youth are allowed ten-minute phone calls every Saturday and Sunday which is given in the case manager’s office and a telephone log is kept. The telephone number, time the call started and ended, and person called is recorded in the youth’s telephone log. Visitation is allowed for immediate family members on Saturday and Sunday. Five youth were interviewed, and all stated they are allowed to send mail and participate in visitation.

5.24 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, procedure, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

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

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

5.26 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, procedure, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

Program Name: Alachua Academy
Provider Name: Sequel TSI of Florida, LLC
Location: Alachua County / Circuit 8
Review Date(s): December 11-14, 2018

MQI Program Code: 1165
Contract Number: 10189
Number of Beds: 28
Lead Reviewer Code: 157

Overall Rating Summary

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

Limited Ratings	Failed Ratings
2.09 Performance Plan Development, Goals and Transmittal*	1.08 In-Service Training
2.11 Performance Summaries and Transmittals	
2.16 Career Education	
2.20 Exit Portfolio	
3.04 MH/SA Admission Screening	
4.39 Prenatal and Neonatal Staff Education	