STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Bartow Youth Academy

True Core Behavioral Solutions, LLC
(Contract Provider)
2415 Bob Phillips Road
Bartow, Florida 33830

Review Date(s): October 8-11, 2019

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

Ratings were assigned to each indicator by the review team using the following definitions:

Satisfactory Compliance	No exceptions to the requirements of the indicator; or limited, unintentional, and/or non-systemic exceptions which do not result in reduced or substandard service delivery; or systemic exceptions with corrective action already applied and demonstrated.
Limited Compliance	Systemic exceptions to the requirements of the indicator; exceptions to the requirements of the indicator which result in the interruption of service delivery; and/or typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator which typically requires immediate follow-up and response to remediate the issue and ensure service delivery.

Review Team

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

Kamille Payne, Office of Program Accountability, Lead Reviewer (Standard 1)
Paul Czigan, Office of Program Accountability, Regional Monitor (Standard 5)
Felicia Goldstein, Office of Program Accountability, Regional Monitor (Interviews)
Stephanie Lobzun, Office of Program Accountability, Regional Monitor (Standard 2)
Joey Nice, Office of Program Accountability, Regional Monitor (Standard 2)
Crystal Shannon, Sequel Youth and Family Services, LLC, Health Services Administrator (Standard 4)
Paul Sheffer, Office of Program Accountability, Regional Monitor (Standard 3)

Program Name: Bartow Youth Academy
Provider Name: True Core Behavioral Solutions LLC
Location: Polk County / Circuit 10
Review Date(s): October 8-11, 2019

MQI Program Code: 1268
Contract Number: R2118
Number of Beds: 28
Lead Reviewer Code: 161

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
3.11 Suicide Prevention Services *	5.26 Safety Planning Process for Youth
4.16 Medication/Sharps Inventory and Storage Process	
5.05 Census, Counts, and Tracking	
5.09 Searches and Full Body Visual Searches	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Youth Supervision *	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	Ten Minute Checks *	Satisfactory
5.05	Census, Counts, and Tracking	Limited
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	Limited
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 Handling and Supervison of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.20	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.21	Elements of the Water Safety Plan, Staff Training, and Swim Test *	Non-Applicable
5.22	Visitation and Communication	Satisfactory
5.23	Search and Inspection of Controlled Observation Room	Non-Applicable
5.24	Controlled Observation	Non-Applicable
5.25	Controlled Observation Safety Checks and Release Procedures	Non-Applicable
5.26	Safety Planning Process for Youth	Failed

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Program Overview

The Bartow Youth Academy is a twenty-eight bed program, for fourteen to nineteen year old males, located in Bartow, Florida. The program is operated by True Core Behavioral Solutions, LLC, through a contract with the Department. The program provides services for a youth population diagnosed as Borderline Developmentally Disabled. In addition, the program fosters each youth by providing Life Skills Training, Skillstreaming the Adolescent, Life-Centered Education, Art/Play Therapy, Anger Management, Boy's Council, Young Men's Work, Living in Balance, and Restorative Justice. Additional treatment services provided includes individual and family therapy, group therapy, and recreational therapy. Program administration is comprised of a facility administrator and assistant facility administrator. Case management services are provided by the mental health staff. Mental health staff at the program includes a designated mental health clinical authority who is a licensed social worker, four non-licensed master's level clinicians, and a recreational therapist. Medical services are offered Monday through Friday from 8:00 a.m. through 5:00 p.m. and are provided by one registered nurse who acts as the health services administrator. Educational services are provided by the Polk County School District. The layout of the program includes: one main building and one portable building. The main building houses one small and large living unit, master control, two multi-purpose rooms, and staff offices. The portable building houses an additional classroom and multi-purpose room. The program has twenty-seven security cameras providing coverage, each of which were operation at the time of the annual compliance review. At the time of the annual compliance review, the program had three vacant positions; three youth care workers. The program reported they have not had air conditioning in portions of the main building since June 2019 and are working with the Department to replace the unit. During a program tour, all interior areas and exterior grounds appeared to be in good condition and well-maintained.

Strengths and Innovative Approaches

- The program consistently engaged youth throughout the annual compliance review period with guest speakers. Topics covered a wide variety of areas including second chances and sexual consent.

- The program tailored their off-site outings to their borderline developmentally disabled (BDD) population and used each incentive outing as a chance to develop life skills. In addition, youth and staff develop a behavior contract for each youth designed to help them develop new skills and make behavioral changes. Youth are given tangible rewards and reinforcements when they display these positive changes.

- The program provided all youth an opportunity to achieve their cardio pulmonary resuscitation (CPR) certifications through a CPR class held at the program.

Standard 1: Management Accountability

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

The program has a policy and procedures outlining requirements for the initial background screening of newly hired staff. During the annual compliance review period, the program hired four new staff, two interns, and re-hired one previously employed staff. Each of the seven staff had clear and eligible background screenings in the Agency for Healthcare Administration (AHCA) Clearinghouse. In addition, each of the seven staff records had documentation indicating the criminal history report, Staff Verification System module, Central Communications Center (CCC) personal involvement history, and Florida Department of Law Enforcement (FDLE) Automated Training Management System (ATMS) were reviewed prior to hire. None of the seven staff required an exemption prior to hire. Five of the seven background screenings indicated the background screening was completed prior to hire. Two staff were hired one day and seven days prior to their background screenings being completed; however, documentation was provided showing both staff were in training off-site, without access to youth or records until after their background screenings were completed. The four new staff were applicable for pre-employment background screenings and each was completed with a passing score as required; the re-hired staff and interns were not required to complete pre-employment assessment tools. The four new staff and one re-hired staff were added to the program's AHCA Clearinghouse roster; however, the two interns were not added. The program submitted their Annual Affidavit of Compliance with Level 2 Screenings Standards to the Department's Background Screening Unit (BSU) on December 3, 2018. The Polk County School Board, who provides teachers for the program, submitted their Annual Affidavit of Compliance with Level 2 Screening Standards to the BSU on November 24, 2018.

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 requiring the background rescreening of all staff every five years of employment. A review of the program's staff, contractor, volunteer, and intern rosters indicated the program had two applicable staff for rescreenings and both were submitted and completed, as required.

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

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

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

The program has a policy and procedures in place which outline the provision for an abuse free environment for staff and youth utilizing trauma responsive principles to ensure youth are free from physical, psychological, and emotional abuse. In addition, the policy requires staff to provide youth unhindered and immediate access to the Florida Abuse Hotline or the Central Communications Center (CCC), if they are over the age of eighteen. During the annual compliance review, the program, youth, and staff all completed Trauma Responsive and Caring Environment (TRACE) self-assessments to assist them in incorporating trauma responsive principles into the program environment. Each staff is required to sign an Affidavit of Good Moral Character upon hire which outlines the code of conduct required for staff. A review of five pre-service and five in-service staff records found each staff signed the affidavit upon hire. A review of CCC reports, incident reports, and youth records since the last annual compliance review found one instance in which a youth made allegations of abuse against two staff. The instance was reported to the Florida Abuse Hotline and CCC. The incident resulted in a substantiated finding for one of the staff for violation of policy; however, the allegation of abuse was unfounded for both staff.

During a program tour, the annual compliance review team observed postings of the Florida Abuse Hotline, CCC, and 9-1-1 contact information throughout the program. The facility administrator explained all youth and staff have access to the Florida Abuse Hotline, CCC, and 9-1-1 to report allegations of abuse or other incidents. Further, the program utilizes written corrective action, performance improvement plans, suspension, or termination in the event a staff is found to have violated the code of conduct. Five staff were interviewed and each reported if a youth wishes to call the Florida Abuse Hotline, or CCC if they are older than eighteen years old, the supervisor is notified and the supervisor assists the youth in making the call. Four staff reported the youth are allowed to make the call, and three staff reported they would notify the facility administrator. One staff reported they believed they had seventy-to

hours to allow youth an abuse call and the youth all call the Florida Abuse Hotline, even if they are over the age of eighteen. The responses of the one staff were addressed with program management. Each of the five interviewed staff reported they had never seen a co-worker deny a youth an abuse call or use profanity, threats, humiliation, or intimidation toward the youth. Five youth interviews were conducted and two youth reported they had never been prevented from calling the Florida Abuse Hotline, three said they never asked to call the Florida Abuse Hotline. Each of the five youth reported feeling safe at the program and staff were respectful when speaking with youth. Four of the youth also said staff never used threats, profanity, or humiliation towards youth; one youth reported they heard staff use profanity on one occasion, but it was not directed at the youth.

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.	

A review of Central Communications Center (CCC) reports, incident reports, and youth records since the last annual compliance review found one instance in which a youth made allegations of abuse against two staff. The instance was reported to the Florida Abuse Hotline and CCC. The incident resulted in substantiated findings for one of the staff for violation of policy; however, the allegation of abuse was unfounded for both staff, which was confirmed through an interview with facility administrator. Documentation found the facility administrator conducted an investigation into the incident and responded to the findings by assigning the staff a corrective action and re-training for the violation of policy.

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

The program had four incidents during the annual compliance review period reported to the Central Communications Center (CCC). Each of the four incidents, which included two medical incidents, one complaint against staff, and one youth behavior incident, were called into the CCC within the required two-hour timeframe and documented in the program logbook. A review of incidents, grievances, and youth records found no additional incidents which should have been reported to the CCC. The facility administrator (FA) was interviewed and reported everyone has access to contact the CCC; however, it is generally the FA, assistant facility administrator, clinical director, or health services administrator who would report an incident to the CCC.

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 had six incidents of utilizing a Protective Action Response (PAR) during the annual compliance review period, five of which were reviewed. Four of the five PARs included a PAR report completed by the end of the workday by all involved staff and reviewed by the supervisor, PAR instructor, and administrator, as required. The fifth PAR report was not completed until a youth alleged abuse based on the incident one month later. After an investigation, it was determined the PAR report should have been completed and corrective action and re-training were assigned to the staff member responsible. At the time of the incidents, none of the PARs resulted in an injury or required the Florida Abuse Hotline to be contacted. Each of the PAR incidents included a post-PAR interview conducted within thirty minutes of the incident and one incident required a PAR Medical Review which was conducted, as required. One incident involved the use of mechanical restraints in which proper techniques were utilized, a Mechanical Restraint Supervision Log was completed, and the youth was appropriately supervised. The facility administrator's (FA) review of the incident indicated corrective action was necessary. Documentation was provided showing the FA investigated the incident and found the staff did not have proper approval to utilize mechanical restraints and was assigned a corrective action and re-training as a result. The PAR reports were all found in a centralized PAR report binder and the program submitted monthly PAR reports to the Department as required. The program's PAR rate is 0.63, which is below than the statewide average of 1.59. In addition, the PAR rate is less than the previous annual compliance review period. The program submitted the PAR plan which was approved by the Department on December 21, 2018. An interview with the FA revealed all PAR incidents are reviewed by the FA and assistant facility administrator, video of the incident is reviewed, and the incident is discussed during the morning management meeting.

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

Five staff pre-service training records were reviewed for certification requirements. Each of the five staff completed all required training in cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), professionalism and ethics, suicide prevention/intervention, emergency procedures, child abuse reporting, Prison Rape Elimination Act (PREA), and Active Shooter prior to contact with youth. In addition, two of the staff completed all required Department and contract trainings. The other three staff completed all training except one contract-required training, staff stress management. All trainings were documented in the Department's Learning Management System (SkillPro). Each of the five staff was certified and completed more than 120-hours of training within 180-days of hire. Documentation was provided to confirm instructors of CPR/first aid/AED and PAR training were qualified to deliver training. The program operates on a pre-service training plan which was submitted to the Department's Staff Development and Training on January 10, 2019 and approved January 16, 2019.

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

Five staff records were reviewed for in-service training requirements. Each of the five staff completed more than twenty-four hours of training in the required topics of cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), professionalism and ethics, and suicide prevention. Two of the five staff were applicable for supervisory training and each completed at least eight hours of supervisory training in the areas of management, leadership, personal accountability, employee relations, and communication skills. All training was documented in the Department's Learning Management System (SkillPro). Documentation supported all facilitators of first aid/CPR/AED and PAR training were certified to deliver the trainings. A review of the staff roster found only direct care staff and supervisors are responsible for the supervision of youth and each have current training, as required. The program operates training based on an in-service training plan which was submitted to the Department's Staff Development and Training on January 10, 2019. In addition, an annual calendar, which is updated as changes occur, is utilized to help administrators track completion of required trainings.

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 outlining the grievance process, which includes the training requirements for all newly hired staff to complete grievance training during the pre-service process. The grievance process includes an informal phase, Speak Out forms, formal phase, and appeal phase. Timeframes are included for each phase of the process. An interview with the facility administrator (FA) confirmed the grievance process. A review of the program's grievance binder found the program maintained copies of grievances for the past twelve months; however, the program only had one grievance during the annual compliance review period. The grievance was resolved in the formal phase within the required timeframe. A review of five pre-service training records found each staff completed training in grievances. Five staff were interviewed and each reported the grievance forms are available to youth throughout the program, four reported youth can request assistance in completing the forms and the FA reviews the forms, three described the process as including the three phases, two staff reported each phase and associated timelines, and one staff reported the supervisor reviews the forms. Five youth were interviewed and four reported they had never filed a grievance and one reported they filed a grievance a long time ago. Four of the youth identified grievance forms are found throughout the program, two of the youth reported there are three phases to the grievance process, and one reported there are timelines associated with the phases. Each of the five youth reported they could ask for assistance in filling out a grievance if the needed.

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

The program's contract requires the program to provide delinquency intervention services to all youth, including Life Skills Training (LST), Boy's Council, Life Centered Education (LCE), Skillstreaming the Adolescent, and Young Men's Work (YMW). In addition, groups are also held in Anger Management and Art/Play Therapy. LST is an evidence-based practice, LIB is a promising practice, and Anger Management and Skillstreaming the Adolescent are practices with demonstrated effectiveness. Five mental health clinicians facilitated groups during the annual compliance review period, four of which were non-licensed master's-level clinicians and one was a licensed clinical social worker (LCSW). Staff training records indicated each staff had the required education and experience to deliver delinquency curricula and their education and work experience were considered when assigning staff to deliver the interventions, which was confirmed through an interview with the facility administrator. Each of the five staff was certified in the delivery of each delinquency intervention model, as outlined by the curricula. A review of group sign-in sheets revealed the groups were delivered as outlined with the appropriate facilitators and number of youth in each group.

A review of the program's activity schedule found more than sixty percent of the youth's time is scheduled with structured, planned programming or activities, including time for groups. Five youth mental health records were reviewed and each youth was found to be participating in multiple delinquency interventions which are evidence-based, promising practices, or practices with demonstrated effectiveness. The delinquency interventions each youth was participating in addressed a priority need identified on the Residential Assessment for Youth (RAY) and the youth's performance plan. The designated mental health clinical authority (DMHCA) described delinquency interventions are tailored to the borderline developmentally disabled (BDD) population of the program. Each delinquency intervention is assigned based on youth needs and only the clinical staff, who have met all education and experience requirements, facilitate the interventions. Five youth interviews were conducted and each youth reported they participate in a variety of groups.

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

The program has a policy and procedures which outline all youth must receive life skills groups facilitated by qualified program staff, which is consistent with the program's contract. The program provides three life skills groups, Life Skills Training (LST), Skillstreaming the Adolescent, and Life Centered Education (LCE), which address communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking. Each youth receives each of the different groups while in the program and the groups are facilitated by non-licensed master's-level clinicians or the designated mental health clinical authority (DMHCA), who is a licensed clinical social worker (LCSW). A review of the program's group schedule found the life skills groups were delivered as outlined in the program's contract.

In addition, a review of group sign-in sheets was conducted and confirmed the groups were conducted as outlined on the group schedule and with the appropriate number of youth and qualified facilitators. The DMHCA reported the life skills groups are tailored to the borderline developmentally disabled (BDD) population of the program and groups are assigned to qualified mental health staff for facilitation. Five youth interviews were conducted, and each reported they participate in groups including LST, two youth mentioned additional life skills groups. Each of the youth described skills they learned in the groups and confirmed they are given the opportunity to practice these skills in group.

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's contract requires restorative justice activities to be offered for each youth throughout programming. A review of the program's group schedule revealed the program has restorative justice groups once a week. The program utilizes The Council for Boys and Young Men and Skillstreaming the Adolescent, which both have restorative justice components, as the restorative justice curriculums in the program. A review of group documentation found the group addressed assisting youth in accepting responsibility, teaching youth about the impact of crime, exposes youth to victims' perspective, and provide youth opportunities to participate in reparation activities. A review of five pre-service training records found all staff completed training in restorative justice. A review of group sign-in sheets found all restorative justice groups were facilitated as outlined by the group schedule by non-licensed master's-level mental health clinicians. Additional documentation was provided to demonstrate the program engages youth in additional restorative justice topics during Art/Play Therapy, Skillstreaming the Adolescent, and Young Men's Work, covering topics which included giving back to the community, community awareness, and reparation. An interview with the facility administrator revealed the youth also participated in a food bank initiative in which eligible youth helped deliver the food to the food bank and a victim services professional recently came and spoke to the youth. A review of five youth mental health records found each youth received services in restorative justice. The restorative justice group is held on Saturdays; therefore, restorative justice activities were unable to be observed during the annual compliance review. Five youth interviews were conducted, and each youth reported they participate in a variety of groups.

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

The program's contract outlines two required groups for gender-specific programming, Young Men's Work and Boy's Council. These services address the gender-specific needs of the youth at the program. All services provided in the program are tailored to the program's population of teenage boys who are diagnosed as borderline developmentally disabled (BDD). A review of the program's groups schedule found both Young Men's Work and Boy's Council were offered as required by the program's contract and their delivery was confirmed through interviews with the facility administrator and designated mental health clinical authority (DMHCA). Group sign-in sheets and the group curricula confirmed the groups were held as outlined with the appropriate

number of youth and facilitated by qualified mental health staff. Five youth interviews were conducted, and each youth reported they participate in a variety of groups.

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 in place which outline how alerts are identified, documented, updated, and communicated to staff. The program utilizes an alert board in master control, which is inaccessible to youth, in addition to a medical alert log to document internal alerts. A review of the Department's Juvenile Justice Information System (JJIS) alerts and the program's internal alerts revealed both alert lists were consistent with one another. The program's internal alert log still includes diagnoses, including asthma, obesity, and psychotropic medications; the requirement to no longer include diagnoses was discussed with the program. An interview with the facility administrator (FA) confirmed the program's alert process and described clinical staff update clinical and case management alerts, the administration updates security alerts, and medical updates medical alerts. Five youth records were reviewed for all alerts of each youth. The review of alerts and logbooks confirmed each alert was entered, updated, and closed, as required, by the appropriate staff and documented in the logbook, if applicable. One gang alert was entered one month late; all additional alerts were opened and closed appropriately within proper timeframes. A review of records in case management, mental health, and medical services did not reveal any issues with alerts. Five staff interviews were conducted, and each staff reported they are informed of alerts through the alert board, logbook, and during shift briefings. The FA also reported alerts are discussed at daily morning management meetings.

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 two separate records for each youth, an individual healthcare record, and a management record which includes case management and clinical information. The file tab in each youth record included all required identifying information in both the management and medical records. All records were labeled as "confidential." Management records are kept on bookshelves marked as "confidential" in the clinical/case management office which is locked when unoccupied and inaccessible to youth. Medical records are kept on bookshelves marked as confidential in the locked medical office.

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 in place to provide opportunities to youth to provide input into the program. An interview with the facility administrator and a review of documentation revealed the program provides opportunities for youth to provide input through a youth advisory board, Let's Talk forms, and youth surveys. Monthly advisory board meetings and Let's Talk forms confirmed youth are given opportunities to provide input. Five youth interviews were conducted and four reported they have daily check-in meetings, one youth reported they can use Let's Talk forms to provide input, and one youth was unsure of a way to provide input.

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

The program has a community advisory board which meets on a quarterly basis and is combined with another program in the same community. A review of meeting minutes found the meetings were held, as required, and each meeting spent time discussing each program separately. A review of meeting sign-in sheets, the board roster, and solicitation efforts by the program found active involvement by members of the business community, school board, faith community, and other community partners. The board roster listed a representative from the judiciary and a victim services advocate; however, neither of those members attended a meeting during the annual compliance review period. The program reported the judiciary member just retired and had not been removed from the list or replaced. The victim advocate was not able to attend any of the board meetings; however, documentation was provided the representative is involved at the program, including speaking to youth on restorative justice and victim services issues. Certified letters were found soliciting participation from a law enforcement representative, parent/guardian, and Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex (LGBTQI) community representative. A returned letter indicated the program received confirmation a former client's parent/guardian was interested in the board and would attend the next meeting. Law enforcement and LGBTQI representatives had not responded to solicitation efforts. An interview with the facility administrator confirmed solicitation efforts and described board involvement in the program including helping to provide education and vocational services to youth, providing Christmas gifts and meals, and helping to coordinate community service outreach opportunities. A board member was not able to be interviewed during the annual compliance review.

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

The program has a policy and procedures in place to determine the system of staff communication and opportunities for youth, staff, and parents/guardians to provide input and feedback into the program. Youth and parent/guardian surveys, conducted at the beginning, during, and end of youth's time in the program were found. The results and recommendations of these surveys, in addition to different performance reports, such as the Monitoring and Quality Improvement Report and the Department's Comprehensive Accountability Report were found to

be discussed during monthly staff meetings and incorporated into programming. An interview with the facility administrator confirmed the surveys and reports are shared with staff at the monthly all-staff meetings and the strengths of the program are emphasized. In addition, these reports are discussed in the daily morning management meetings.

The facility administrator discussed efforts to maintain appropriate staffing and efforts in place to minimize turnover and improve staff morale. Documentation confirmed most staff have been at the program for over one year. In addition, documentation supported the program management employed multiple efforts to improve staff morale, including themed employee appreciation days, awarding of employee of the month and year, The TrueCore Way initiative, football Fridays, lunch at the all-staff meetings, and staff raffles. In addition, the program's policy and practice established several processes for staff communication which includes the all-staff meetings, shift briefings, and logbook documentation. Five staff were interviewed and each confirmed all-staff meetings are held monthly and all topics are discussed and valuable at the meetings. Three of the five staff reported they are briefed on survey results and performance reports; however, two reported they were not. Two staff reported communication is very good, one reported communication is good, and two reported it is fair. Two staff further explained shift-to-shift communication could be improved as supervisors do not always have the information needed and staff time-off isn't shared to help staff know if they will be held over on their shifts ahead of time. Each of the five staff reported the facility administrator has an open-door policy and they are able to share any concerns or suggestions any time.

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 in place which outlines requirements for evaluating staff performance annually and after the first ninety-days of hire. A review of position descriptions confirmed job duties are clearly outlined for each staff member. A review of five pre-service staff records found each staff received a ninety-day performance evaluation and a review of five in-service staff records found each staff received an annual performance evaluation. Each of the ten staff were evaluated based on established performance standards outlined in their position descriptions which they received and signed upon hire. All required positions in the program's contract are maintained and performed as required based on the position descriptions and reviewed documentation. The facility administrator confirmed evaluations are completed after the first ninety days and annually thereafter. Five staff were interviewed and three confirmed they received their ninety-day evaluations, two staff reported being evaluated every six months. One staff discussed they are given coaching sheets from their supervisor in addition to evaluations.

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

The program has a policy and procedures outlining the provision for recreation and leisure activities which are appropriate for the borderline developmentally disabled (BDD) population at the program. A review of the program's activity schedule documents youth are given the opportunity to participate in a wide-range of indoor and outdoor recreation and leisure activities. During recreation time, the youth participate in the prescribed activity on the recreation calendar or an alternative indoor workout of the day if weather does not permit outside time. In the

evenings and on weekends, youth are given a choice of leisure activities. Youth are encouraged to explore interests during recreation and leisure time. Youth are afforded opportunities to provide input into offered activities through the Youth Advisory Board and Let's Talk forms. Recreation is documented through movement if the youth are outside; however, the logbook does not document recreation if weather does not permit youth to go outside. Water coolers were found and an observation of indoor recreation was made to verify staff take precautionary measures to protect youth from over-exertion and environmental stressors. Five youth and five staff interviews were conducted, and each reported youth receive recreation for an hour a day. When outside, youth engage in activities such as basketball, football, relay races, four-square, and workouts. When indoors, youth participate in workouts, yoga, and video workouts.

The program's contract requires a recreation therapist. The program's recreation therapist is a Certified Therapeutic Recreation Specialist who meets all education and experience requirements. A recreation schedule was found outlining daily activities. In addition, the recreation therapist created workouts for youth when weather conditions did not allow them to be outside. An incentive schedule was also created by the recreation therapist and posted throughout the program to allow youth to see the daily activity they could participate in with good behavior. During the annual compliance review, the review team observed the youth engaged in an indoor workout of the day which included different exercises, use of battle ropes, and other activities.

Standard 2: Assessment and Performance Plan

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

The program has a policy and procedures in place outlining the program's intake and admission process. The program's policy indicates the youth's parent/guardian will be notified by telephone and sent written notification of the youth's admission to the program. The policy further indicates the youth's committing court, juvenile probation officer (JPO), and post-residential services counselor will be notified, in writing, of the youth's admission to the program. A review of five youth case management records indicated each youth's parent/guardian was notified by telephone and in writing of the youth's admission to the program. All records contained a letter dated the day of the youth's admission which was sent to the committing court judge, JPO, and post-residential services counselor notifying them of the youth's admission.

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

The program has a policy and procedures in place to ensure each youth is oriented to the program within twenty-four hours of their admission. A review of five youth case management records contained documentation indicating all of the youth were oriented to the program on the day of their admission. All reviewed records contained documentation each youth was oriented to the expectations and responsibilities, program's behavior management system, daily schedule, access and availability to medical and mental health services, Florida Abuse Hotline numbers, items considered to be contraband, performance planning, anticipated length of stay, dress code and hygiene, procedures for visitation, community access, services, grievance process, emergency procedures, physical design of the facility, treatment team meetings, and assignment of the youth to a living unit. All five youth admissions and intakes were denoted in the master control logbook. During the annual compliance review, the program did not have any youth admitted to the program; therefore, the process could not be observed.

Five youth were interviewed and each indicated they were oriented to the program within twenty-four hours of their admission. Three of the five youth indicated the clinical care manager went over the program's orientation form with them and explained the program's rules and levels. One of the youth indicated the care manager went over the youth handbook with them and the program's level system. Another youth indicated they couldn't play outside for fourteen days and had to take a test on the orientation information.

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 in place for obtaining written consent of youth who are eighteen years of age or older for the release of mental health, medical, and substance abuse information. A review of five youth case management records revealed one was applicable for consent for youth eighteen years or older. The program provided two additional youth records applicable for review. All three applicable records contained a program form entitled Authorization for Use or Disclosure of Protected Health Information which documents the youth's consent for providing or discussing any information regarding the youth's mental health, education, and case management to the individuals listed on the form. One of the reviewed forms indicated it was signed by the youth during their admission, and the other two youth signed the consents on their eighteenth birthday while in the program.

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

The program has a policy and procedures in place outlining the program's classification process. The program's classification system is designed to protect youth through appropriate living unit placement, sleeping room arrangements, and youth group or staff advisor assignments, as well as provide a comprehensive orientation to the program. The policy also indicates all youth shall be assessed for risk to security and public safety upon admission and regularly thereafter. The purpose of the assessment is to determine the degree to which the youth is a risk to others or themselves, if allowed to participate in training or work projects involving the use of tools (i.e., vocational programming), in activities where access to tools is possible, and to be allowed participation in off-campus activities, including home visits. The program has an internal alert board in master control which identified each youth's classified risks and it is accessible to staff at any time. The alert board indicates gang affiliation, security alert, escape risk, medical alerts, and restrictions. A review of five youth case management records revealed all youth had an initial classification meeting which reviewed factors such as the youth physical characteristics, age, maturity level, identified special needs, history of violence, gang affiliation, criminal behavior, and sexual aggression or vulnerability to victimization. The classification form also identifies risk factors such as suicide risk, medical risk, escape risk, and security risk. Four of the five youth were classified as being a medical risk. One of the five youth was classified as being a security risk. None of the five youth were classified as being at risk for suicide or an escape risk. All five initial classification forms indicated the youth were classified for the purposes of assigning them to a living area, sleeping room, youth group, and/or staff advisor. One of the five youth records contained a re-classification for changing the

youth's living unit due to fighting and the need to separate the youth from youth they fought with. The program maintains all risk classification forms in a binder labeled as such. Each youth receives a new risk assessment at their monthly formal treatment team meeting. A review of five youth case management records revealed each youth received risk assessments at their formal treatment team meetings. A review of the five records revealed there were a total of fourteen risk classifications completed and all risk assessments were completed correctly with no issues.

An interview with the facility administrator (FA) confirmed the program is completing risk assessments on the youth monthly. The FA indicated newly admitted youth are normally placed in bedrooms in the front of the dormitories. The FA also indicated the program reviews each youth's mental health status/concerns, age, body type, and maturity when assigning the youth to a room.

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 outlining the program's process for gang prevention and intervention. The purpose of the program's policy is to prevent and deter the introduction of criminal street gang activity into the program, and to ensure the sharing of gang-related information with the appropriate agencies. A review of five youth case management records indicated one youth was applicable for gang identification and notification to law enforcement. The program provided two additional youth records for review of gang identification and notification. All three applicable records contained documentation local law enforcement was notified, in writing, of each youth's presence in the county and of each youth's gang affiliations. Two of the three records contained written documentation to support each youth's home county sheriff's department and local school district, were notified of the youth's gang affiliation and placement into the program. The third record was a youth who was from the county in which the program is located, and they were already previously notified of the youth's gang affiliation. All three records contained documentation to support each youth's juvenile probation officer (JPO) was notified of the youth's gang affiliation and placement in the program.

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

The program has a policy and procedures in place outlining the program's process for gang prevention and intervention. The program's community care manager conducts monthly gang prevention and intervention groups with the youth designated as a gang member, gang associate, or suspected gang member. The program utilizes the Gang Deterrence: Impact of Gangs on themselves, Families, Communities, and Future as the gang curriculum provided at the program. A review of the group sign-in sheets confirmed the program conducted monthly gang groups for the entire annual compliance review period. Topics covered in the gang groups were peer pressure, what's in your neck of the woods, identifying triggers, effects of incarceration, and gang members and gang activity implications. A review of five youth case management records confirmed there was one youth who was identified as either a gang member, gang associate, or as having suspected gang affiliations and were required to

participate in the monthly gang groups. The program provided two additional records where the youth was designated as having gang affiliations. A review of the three applicable records confirmed the youth attended monthly gang groups since their admission. The sign-in sheets for the gang group also confirmed each youth attended the gang group every month or they started the group the month they entered the program. During the program tour, the annual compliance review team did not observe any gang graffiti. All three applicable records were reviewed to ensure each youth's performance plan included a relevant goal(s) and/or objective relating to gang intervention strategies for the youth to complete while they are in the program. Each of the youth's performance plan had a gang goal indicating they would participate in the monthly gang groups.

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

The program has a policy and procedures in place for the completion of the Residential Assessment for Youth (RAY) assessments and re-assessments. The policy indicates the program will complete a RAY on each youth within thirty days of admission. A review of five youth case management records indicated all records contained a completed RAY within thirty days of admission. All initial RAY assessments were completed in the Department's Juvenile Justice Information System (JJIS).

The program's policy indicates RAY reassessments will be completed on each youth every ninety days. A review of five youth case management records indicated one record was applicable for a RAY reassessment. The program provided two additional records for review to ensure a minimum sample of three records were reviewed. All three applicable records contained RAY reassessments completed within ninety days of the original assessment. All RAY reassessments were completed in JJIS and a copy was maintained in each youth's case management record.

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

The program has a policy and procedures in place for the completion of the Youth Needs Assessment Summary (YNAS) within thirty days of each youth's admission. A review of five youth case management records indicated four of the five records contained a completed YNAS within thirty days of admission. The fifth record contained a YNAS completed thirty-one days after the youth's admission. All YNAS documents were completed in the Department's Juvenile Justice Information System (JJIS) database and a copy was maintained in each youth's case management record.

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

The program has a policy and procedures in place for the development of performance plans based on the findings from the initial assessments, and within thirty days of the youth's admission to the program. The program holds a needs assessment meeting with the treatment team to gather information for the youth's performance plan. Each treatment team member signs the needs assessment form indicating they participated in the assessment and development of the performance plan.

A review of five youth case management records revealed all performance plans were completed after the completion of the Residential Assessment for Youth (RAY) and Youth Needs Assessment Summary (YNAS). Four of the five reviewed records contained performance plans developed within thirty days of the youth's admission. The fifth record was developed thirty-one days after the youths' admission. Four of the five records reflected the youth, treatment team leader, administrative representative, living unit representative, other treatment team members, and educational staff were present for the development of each youth's performance plan. The fifth record reflected the administrative representative and education staff were not present for the development of the performance plan and signed the plan two days after the plan was developed and signed by all other parties. Four of the five performance plans were signed by the youth, treatment team leader, and all parties responsible for goal completion. Two of the five performance plans were signed by the youth's parent/guardian; however, there was documentation in the remaining three records the program requested the parent/guardian sign the plan and return it to the program. The program never received a signed copy from each of the three parent/guardians. All reviewed performance plans contained individualized goals based upon the prioritized needs reflecting the risk and protective factors identified during the initial assessment process. All five performance plans addressed each youth's top three criminogenic needs, and contained specific delinquency interventions with measurable outcomes, which decrease criminogenic risk factors, and promote strengths, skills, and reduce the youth's risk of reoffending. All five performance plans contained a goal targeting each youth's court-ordered sanctions, and contained transition goals, which were deferred until the youth reached the transition phase of the program. All plans described the youth's responsibilities to accomplish the goals and the program's staff's responsibilities to help the youth complete the goals. All plans contained target dates for goal completion. A copy of all five youth's performance plans were sent to each youth's committing court Judge and parent/guardian within ten days of completion.

Interviews with five youth indicated they all participated in the development of their performance plan and they were able to articulate the individuals who were present when their plans were developed. The interviewed youth indicated they were currently working on anger management, coping skills, decision making skills, responsibility, changing behaviors and respect. All five youth confirmed they received a copy of their performance plan.

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

The program has a policy and procedures in place which indicates a youth's performance plan will be modified based on any changes to the youth's Residential Assessment for Youth (RAY), the youth's demonstrated progress toward completing a goal, and/or lack of progress toward completing a goal. A review of five youth case management records revealed two of the records contained performance plan revisions; the other three records were not applicable for performance plan revisions. The program provided one additional record for review of performance plan revisions. All three records contained performance plan revisions based on newly acquired or revealed information; however, revisions were not needed based on the youth's RAY reassessments or a change in their needs. Two of the records also contained revisions based on the youth's demonstration of progress toward goal completion.

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

The program has a policy and procedures in place which addresses the completion of performance summaries and their transmittal. A review of five youth case management records revealed one was applicable for ninety-day performance summaries. The program provided two additional records to review. All three applicable records contained a performance summary completed ninety days after the completion of the original performance plan. None of the reviewed records were applicable for performance summaries prior to the youth's release, discharge, or transfer from the program.

All summaries contained information regarding the youth's status for each performance plan goal, youth's overall treatment progress, academic status and/or credits, behavior, interaction with peers, interaction with staff, overall behavior adjustment to the program, and significant positive and negative events. Two of the three records contained information regarding the youth's level of motivation and readiness to change. The third record did not have the information documented in the summary and the program acknowledged the missing information. All three applicable records contained documentation indicating the youth could read and add comments to their performance summaries. Documentation supported each youth received a copy of their performance summary and the original summary was filed in the youth's

case management record. All performance summaries were signed and dated by the treatment team lead, staff member preparing the summary, facility administrator, and the youth. All three records contained documentation to support each performance summary was sent to the committing court, juvenile probation office, youth, and parent/guardian within ten days of completion.

Three closed records were reviewed for discharge and release summaries. All three records contained the original release summary which included the justification for the youth's release from the program. Two of the three reviewed records contained a Pre-Release Notification (PRN), completed forty-five days prior to the youth's release. The third record contained a PRN which was completed forty-one days prior to the youth's release and was late by four days. All summaries and PRNs were signed by the appropriate parties and maintained in the youth's closed case management record. All three records contained notification to the parent/guardian confirming the youth's release date once the program received the approved PRN from the committing court. All three records contained a completed Exit Residential Assessment for Youth (RAY) assessment. None of the three reviewed closed records were for youth who were considered sexually violent predators and did not require additional discharge documentation or notifications. None of the records required victim notification prior to the youth's release from the program. Interviews with five youth indicated four of the five youth received a copy of their performance summaries and the fifth youth was not applicable for the completion of a performance summary.

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

The program encourages the parent/guardians of each youth to participate in the youth's case management treatment services. At the time of admission, the program mails each parent/guardian an admission letter outlining the case management process and encouraging the parents/guardians to participate in an online survey, as well as in the performance plan and treatment plan process. Attached to the admission letter is a copy of the program's parent handbook, which outlines who will be working with their child, how the program works, treatment and performance team members, medical care, ways of communicating with their child, visitation, program level system, privileges, consequences for negative behaviors, transition planning, assessments, and the grievance process. A review of five youth case management records revealed each youth had regular telephone contact with their parent/guardian. There was also documentation to support the case manager had regular contact with the parent/guardian to update them on the youth's progress in the program. Four of the five records also contained documentation to support the parent/guardians were invited to participate in the youth's performance planning and treatment meetings. The fifth record did not document the parent/guardian received advance notice of the youth's treatment team meetings; however, the youth's parent/guardian did participate in the youth's treatment team meetings. The program provided documentation to support they have quarterly family days and indicated letters are mailed to the parents/guardians inviting them to attend.

An interview with the facility administrator (FA) indicated the program encourages parental involvement in the case management process by contacting the parent/guardian during the admission process, treatment teams, treatment and performance planning and reviews, and by having family days at the program. The FA also indicated the parent/guardians are contacted

when behavioral issues arise with the youth or during special incentives such as birthdays, holidays, and extraordinary events. An interview with the facility administrator (FA) indicated the youth are given an admission call to their parent/guardians upon arrival. Also, medical staff, as well as clinical care management staff reach out to the parent/guardians on the day of the youth's admission to gather the youth's history. The FA also indicated the clinical case management staff send out parental assessments, have family days and conduct family sessions and the program has visitation every Sunday afternoon.

During the annual compliance review, the review team was able to observe a treatment team meeting. The following individuals were present at the observed treatment team meeting: youth, education representative, living unit representative, facility administration, treatment team lead, therapist, recreational therapist, and community care manager. Present at the meeting by telephone was the youth's juvenile probation officer and parent/guardian. During the meeting, the youth was able to discuss how they were progressing in the program and items they were working on. Each individual member of the treatment team provided information on their perspective program areas.

An interview with five youth indicated they can reach out to their guardians by mail and telephone. All five youth indicated they can call their parents/guardians and other approved family members. The youth also indicated their parent/guardians are invited to participate in family day, therapy sessions and treatment team meetings.

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

The program has a policy and procedures in place outlining the required members of each youth's treatment team. The policy further indicates the multi-disciplinary intervention and treatment team shall be comprised of the youth, parent/guardian, juvenile probation officer (JPO), representative from the program's administration the facility administrator, director of clinical services, representative from the residential living unit, staff mentor, or youth care worker, other's directly responsible for providing or overseeing provision of intervention and treatment services to the youth, and a representative from education staff who could be present or provide written input. The program has designated the youth's clinical care manager as the leader for each intervention and treatment team to coordinate and oversee the team's efforts. A review of five youth case management records revealed each youth was assigned to a treatment team upon their arrival and each youth's treatment team consisted of the individuals required by the program's policy and Department's administrative rule. All five records contained documentation to support the youth's JPO, and other pertinent parties were invited to participate in each youth's treatment team meetings. Four of the five records contained documentation to support the youth's parent/guardian were invited to participate in each youth's treatment team meetings. The fifth record did not contain documentation the youth's parent/guardian was invited to the each of the youths' treatment team meetings; however, the youth's guardian attended the youth's treatment team meetings.

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

The program has a policy and procedures in place for the case management staff to incorporate mental health, substance abuse, and other agencies' performance plans into each youth's performance plan. A review of five youth case management records revealed all youth had mental health and substance abuse treatment plans completed by each youth's clinical care manager. Each of the performance plans included a goal for the youth to work towards while completing treatment services at the program, thus incorporating the mental health and substance abuse plan into the performance plan. Two of the five records contained individualized academic plans and each of the youth's performance plans contained a goal indicating the youth would work on their specific individualized education plans. None of the five reviewed youth records were youth who were involved with the Department of Children and Families (DCF); however, the program was able to provide two additional records where the youth were involved with DCF. Both records contained goals indicating each youth would work on completing their DCF case plans or work on goals related to their DCF case plans. The program advised there were no youth served by the Agency for Persons with Disabilities during the annual compliance review period.

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

The program has a policy and procedures in place outlining the program's treatment team meetings, which includes formal and informal meetings. A review of five youth case management records revealed the program invites and encourages active participation from the youth's juvenile probation officer (JPO) and other pertinent members of the treatment team through advance written notification. Four of the five records reflected the youth's parent/guardians received advanced notice of all treatment team meetings. The fifth record did not have documentation to support the parent/guardian was given advanced notice of the treatment team meetings; however, the parent/guardian participated by telephone in each of the youth's treatment team meetings.

The program notifies the youth's parent/guardian and JPO of each youth's formal treatment team meeting by either telling them during the current treatment team or by including it on the transmittal letter attached to the performance plan mailed to them. All five reviewed youth records contained documentation supporting formal treatment team meetings were held every thirty days. A review of the records found there was a total of twelve formal treatment team meetings held for the youth. All formal reviews were documented in each youth's case record and included the youth's name, date of review, meeting attendees, comments from treatment team members, a brief synopsis of the youth's progress in the program, performance plan revisions, progress on performance plan goals, positive and negative behaviors, behaviors resulting in physical interventions, treatment progress and Residential Assessment for Youth (RAY) assessment results, when necessary. All reviewed formal treatment team meetings indicated a representative from the program's administration, residential living unit, and other staff directly responsible for services provided to the youth were present at the treatment team,

and there was also written input from the educational staff. There was documentation to support the youth's parent/guardian and JPO were contacted or attempts were made to contact them for their participation in each youth's treatment team meeting by telephone. All five reviewed records also contained documentation to support the clinical care manager and youth participated in bi-weekly informal reviews of the youth's performance plan. There were twelve informal treatment team meetings reviewed for proper documentation. All informal performance reviews documented the youth's name, date of review, meeting attendees, comments by other treatment team members, a synopsis of youth's progress in the program, performance plan revisions, progress of goals, positive and negative behaviors, behaviors which resulted in physical interventions, treatment progress and RAY reassessments, when necessary. A review of the Department's Juvenile Justice Information System (JJIS) indicated each youth's anticipated release date was entered into the system and are updated, when necessary, based on the youth's behavior and progress in the program.

An interview with five youth indicated they are all provided an opportunity during their treatment team meetings to demonstrate skills they have learned in the program. One youth indicated the treatment team members ask what the youth has learned in the program such as sportsmanship, and how the youth would handle situations on the sports field. Another youth indicated they tell the treatment team how they have improved since their last meeting and how they are continuing to do so. A third youth indicated they talk to the treatment team about how they stop their anger from rising and how they learned to focus when people around them are trying to cause fights. The fourth youth indicated they tell the treatment team what they have done in the last month to process and solve problems. The last interviewed youth indicated they explain to the treatment team how they are coping with their anger. The five youth confirmed staff review their performance on goal achievement and their behaviors during the treatment team meetings.

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

The program has a policy and procedures for the development and implementation of a vocational program. An interview with the lead educator confirmed career education is part of the daily planning for academics. Built into core academic classes are opportunities for youth to develop abilities in communication, interpersonal skills, and decision-making skills. Career assessments allow youth to explore and gain knowledge of occupation and vocational options. My Career Shines, an online career exploration service, provides youth opportunities to take career assessments and explore careers. Youth in the program have opportunities to gain vocational skills in a horticulture curriculum and certification in the food service industry.

Three closed youth records were reviewed. All records have evidence of a completed sample employment application and resume and documentation of an appointment with Career Source Center. Each of the three records contained evidence of a sample resume, appropriate documents to obtain employment, and documentation of notification to the parent/guardian being made aware of vocation plan. Documentation in the youth records supported the parent/guardian and juvenile probation officer (JPO) were made aware of this information. This program does not have a contracted minimum length of stay of nine months; therefore, the Career and Professional Education (CAPE) component is not applicable.

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 academic calendar providing educational and career-related programs for 250 days of instruction distributed over a twelve-month period with a minimum of twenty-five hours of instruction weekly. Youth receive credits for educational and training experience. A review of logbooks and interviews with education staff supported education is taking place as scheduled. Five youth interviews were conducted and each youth also confirmed there is minimal interference in education.

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

The program has a policy and procedures in place regarding educational transition planning. Applicable staff and youth at the program complete an education transition plan prior to release including provisions for continuation of education and/or employment. Three closed youth case management records were reviewed, and each contained documentation of an individual education transition plan developed on the youth's post-release goals attended by the youth, parent/guardian, education representative, and post-release staff. The reviewed records documented participation of a certified school counselor and registrar (or designee) in the education planning. All reviewed records contained documentation of services and interventions based on the youth's assessed educational needs and post-release education plans, a recommended educational placement for post-release and specific monitoring responsibilities for coordination of the provision of support services, provisions for continuation of education/employment, a resume, appropriate documents essential to obtain employment, and evidence of the youth's case manager and parent/guardian are aware of the plan.

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

The program has a policy and procedures in place addressing transition planning, conferences, and Community Re-Entry Team (CRT) meetings. Three closed records were reviewed for

compliance with transition planning and CRT meetings. Two of the three reviewed records confirmed each youth had a transition conference completed by the program and held at least sixty days prior to the youth's targeted release date. In the third record reviewed, the youth had a transition conference completed by the program; however, the conference was conducted fifty-four days prior to the youth's release, which is six days late. All three records reflected the youth, treatment team leader, facility administrator or designee, education staff, and other treatment team members attended the transition conference in person. All records reflected the youth's juvenile probation officer (JPO), parent/guardian, and other's pertinent parties were invited to the transition conferences; however, they were unable to attend, and their participation was denoted on the form as participating by telephone. During the transition conference, the following information was discussed: transition activities on the youth's performance plan, the performance plan was revised (when necessary), identifying additional transition activities, identify completion dates for goals, and identify person responsible for completion of goals. All transition plans were signed by the treatment team leader, youth, and all other attendees. There was documentation in all closed records to reflect the JPO received a copy of the youth's transition plan.

The three closed records were reviewed for the completion of a CRT meeting prior to the youth's release. Two of the three records contained documentation the youth and clinical care manager participated in CRT meetings held by each youth's JPO prior to the youth's release. The third record contained documentation the clinical care manager was notified of the meeting and was not able to attend the meeting with the youth. The record did contain documentation to support the clinical care manager followed up with the JPO after the CRT meeting and was provided the information from the meeting. All three youth's CRT meetings were conducted prior to the youth's release and separate from the youth's transition and exit meetings.

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

The program has a policy and procedures in place outlining the program's process for the transition of the youth back into the community. The program develops an exit portfolio for all youth during the transitional phase of the program. A review of three closed youth case management records indicated an exit portfolio was discussed and started at or before the youth's transition meeting. A review of the exit portfolios indicated each youth received a state-issued identification card, a copy of their transition plan, social security card, and a calendar with dates, times, and locations of follow-up appointments in their home community. All three exit portfolios contained a copy of the youth's original birth certification, vocation certificates the youth earned in the program, educational documentation, school transcripts, resume, and completed sample job applications. There was documentation in the educational transition plan in the Department's Juvenile Justice Information System (JJIS) each of the three youth's educational records were forwarded to their home county's school district. There was documentation in all three closed records the youth's exit portfolio was verified and discussed during the exit conference. Documentation in all three records supported each youth received a copy of their exit portfolio upon their release. There was also documentation in all records indicating the case manager sent the entire case management record, along with a copy of the youth's exit portfolio, to the youth's juvenile probation officer.

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

The program has a policy and procedures in place outlining the program's exit process. A review of three closed youth case management records revealed all three youth had an exit conference held after the youth's juvenile probation officer (JPO) was notified of the youth's release date and at least fourteen days prior to the youth's release. All three records contained the program's exit conference form with the date of the conference, signatures of participants, and a summary of the youth's pending transition goals. All exit conference forms indicated the team discussed the youth's transition activities established at the transition conference and finalized the plan for the youth's release. All exit conference forms were signed by the youth, education representative, treatment team leader, transitional services manager, and therapist. All three exit conference forms were either signed by the parent/guardian and JPO or it was denoted they participated in the conference by telephone. A review of the Department's Juvenile Justice Information System database reflected the date of the youth's admission and release date from the program was accurate.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a licensed clinical social worker (LCSW) who serves as the designated mental health clinician authority (DMHCA). The DMHCA is employed full-time by the program and is on-site at least forty hours a week. Th DMHCA is also available twenty-four hours a day, seven days a week in the event of a mental health or substance abuse emergency. A review of the DMHCA license found it to be current and active, with an expiration date of March 31, 2021. An interview with the DMHCA reflected they are responsible for ensuring the timely and accurate completion of the required assessments, evaluations, and treatment plans. In addition, they ensure the treatment programming at the program complies with all requirements outlined in the program's contract. The program will utilize the regional clinical director, who is a licensed mental health counselor, and their assistant clinical director to provide coverage in the absence of the DMHCA for the program. A review of their licenses found both are clear and active, and do not expire until March 31, 2021.

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 has one licensed clinician who is the designated mental health clinician authority (DMHCA) for the program. The DMHCA, who is a licensed clinical social worker (LCSW), provides oversight to all treatment services offered within the program. The program will utilize the regional clinical director, who is a licensed mental health clinician (LMHC) to provide coverage in the absence of the DMHCA for the program. Each of their licenses are clear and active, and do not expire until March 31, 2021. The program also contracts with Psychology Associates of Central Florida (PACF) for the provision of weekly services from a psychologist. PACF has three different psychologists who provided services during this annual compliance review period. Each of these licensed psychologists were found to have clear and active licenses, two expire on May 31, 2020, and the other license expires on November 30, 2019. It was reported this psychologist is currently working to have their license renewed. The program also has a contract with Applied Behavioral Learning Experiences to provide the services of a certified behavioral analyst. The contractor provides the services of two different certified behavioral analysts (CBA) who rotate their coverage on a weekly basis. A review of their certifications found each were current. One certification expires on September 30, 2021 and the

other expires on November 30, 2019. The program indicated the CBA whose certification expires in November is currently working towards having this renewed prior to expiration.

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 a policy and procedures to ensure mental health and substance abuse staff have the appropriate credentials. The program has four non-licensed clinicians who provide both case management and clinical services to youth in the program. Schedules are staggered to ensure the program has clinical staff present seven days a week. Each of the non-licensed mental clinicians hold a master's degree in a relevant field of study. The program was able to provide documentation showing twenty hours on-the-job-training in assessing suicide risk, mental health crisis intervention, and emergency mental health services for each of the non-licensed clinicians. The reviewed documentation also validated the administration of five Assessments of Suicide Risk (ASR) or crisis assessments conducted in the physical presence of a licensed mental health professional, which allows them to conduct ASRs and prepare them for approval by a licensed clinician. A review of direct supervision logs confirmed non-licensed mental health clinical staff were provided with at least one hour on-site face-to-face direct supervision by the designated mental health clinician authority (DMHCA) each week they worked, with no exceptions.

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

The program has a policy and procedures to explain the comprehensive screening process which is conducted on each youth during their admission process. The screening process is included in their Comprehensive Plan for Mental Health and Substance Abuse Services. A review of documentation confirmed the program follows the procedures outlined in the policy. A clinician completes a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) on each youth as part of the admission process. The reviewed documentation in all five reviewed records confirmed this assessment was completed on the day of admission by a clinician and was entered into the Department's Juvenile Justice Information System (JJIS). All of the reviewed MAYSI-2 instruments were conducted by a trained staff. Reviewed documentation also confirmed all available information was reviewed to ensure the staff get a clear picture of the youth's history which is done through the completion of a records review. A review of the following commitment packet information, when available, is completed: Department external comprehensive evaluations, Department face sheet (to include alert information), the Community Assessment Tool (CAT), and any other commitment packet information available. The findings from this review were reported on the admission classification form. Four of the youth's MAYSI-2s indicated a need for further assessment, and each youth was referred for further evaluation through the completion of a new Comprehensive Mental Health/Substance Abuse Bio-Psychosocial Evaluation. None of the youth had a "hit" on the MAYSI-2 in the category for suicide ideation; however, the program conducts an

Assessment of Suicide Risk (ASR) on each youth as part of their admission to determine if there are any concerns which may not have been identified through completion of the MAYSI-2. The program also completes a Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) screening for each youth. This screening is specifically used to assist in room placement when concerns are identified regarding potential victimization. Interviews with the facility administrator and designated mental health clinician authority (DMHCA) confirmed the program's admission process.

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

The program has a policy and procedures defining how to complete a new Comprehensive Mental Health/Substance Abuse Bio-Psychosocial Evaluation for each youth admitted to the program. Four of the five reviewed youth mental health records included a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) which indicated a need for further assessment upon entry to the program. The other youth had no concerns identified on their MAYSI-2; however, program practice is to complete a new Comprehensive Mental Health/Substance Abuse Bio-Psychosocial Evaluation. During the twenty-one days following admission, the clinicians also complete a Substance Abuse Subtle Screening Inventory (SASSI), a Social Skills Improvement System (SSIS) assessment, and either a Trauma System Checklist for Children (TSCC) or a Trauma System Inventory (TSI-2) depending on the youth's age. This information, in addition to recommendations from the initial diagnostic psychiatric evaluation, is used to assist in the completion of each youth's comprehensive evaluation. All five youth records had a new Comprehensive Mental Health/Substance Abuse Bio-Psychosocial Evaluation completed within thirty calendar days of admission. All were completed by a non-licensed clinician, and each had a review by a licensed clinician within one day of completion. Each reviewed assessment included the methods of assessment, identifying information, screening procedures, presenting problem, family history, history of abuse/neglect/trauma, behavioral observations, physical health, developmental history, mental health, mental status exam, substance abuse history and treatment, social history, sexual history, vocational skills, independent living skills, strengths, needs, abilities, transitional planning, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, summary of clinical impressions, and treatment recommendations. The results of the Comprehensive Mental Health/Substance Abuse Bio-Psychosocial Evaluation are used to help develop each youth's individualized treatment plan.

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.*	

Based on a review of five records, each youth was assigned to a treatment team on their day of admission. A review of their mental health/case management records found the specific

assignment of a case manager/clinician for each youth on their classification form. The program's policy designates the remaining members of each youth's treatment team which includes a member of program administration, a living unit representative, a nurse, education staff, and the parent/guardian, when applicable. A review of treatment team documentation confirmed the team consisted of all required members. The mental health and substance abuse daily service progress notes for all five youth were reviewed. The progress notes were documented on a form which contained all the information found on the Department's Group Progress Note form. This review confirmed all five of the youth received services as set forth in their individualized treatment plan, without exception. Four of the five youth had a copy of a properly executed Authorization for Evaluation and Treatment (AET) in their individual healthcare record (IHCR). The other youth was eighteen years old at the time of the review. Each of the five reviewed records contained a signed Youth Consent for Substance Abuse Treatment form, and a signed Youth Consent for Release of Substance Abuse Treatment Records form. A review of all five youth's mental health and substance abuse daily service progress notes, as well as group sign-in sheets, validated mental health groups had no more than ten youth present, and substance abuse groups had no more than fifteen youth present during any group sessions. During the annual compliance review, observations of a mental health treatment group also confirmed no more than ten youth were present. The program has a Chapter 397 license to provide substance abuse services, with an expiration date of April 7, 2020.

An interview with the designated mental health clinician authority (DMHCA) confirmed the program provides mental health and substance abuse treatment groups, family counseling, individual counseling, and psychosocial skills training. The DMHCA indicated treatment groups are conducted seven days a week, individual counseling occurs no less than once a week for each youth, and family counseling is scheduled monthly for each youth, at a minimum. All five interviewed youth indicated they attend group treatment. Specific group curriculums mentioned by one respondent were Life Skills Training (LST) and anger management groups. Four of the five interviewed staff indicated direct care staff do not facilitate mental health or substance abuse treatment groups. The other respondent was a case manager/clinician, and they indicated they do conduct these groups.

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

The program has a comprehensive plan for mental health and substances abuse services which outlines how they will complete their treatment and discharge planning. Each of the five reviewed youth mental health records contained an initial treatment plan which was completed on the day of admission. All were completed on a form which contained all the elements of the Department's Initial Mental Health/Substance Abuse Treatment Plan sample form and were signed by all treatment team members. All five were completed by a non-licensed clinician and

were reviewed by the designated mental health clinician authority (DMHCA) the same day of completion.

All five records also contained an individualized treatment plan which was completed within thirty days of admission. Each plan was signed by the treatment team, to include the non-licensed clinician who prepared the plan, and a review by the DMHCA the day the plans were reviewed and signed by the treatment team. These were completed on a form which had all required elements found on the Department's Individualized Mental Health/Substance Abuse Treatment Plan sample form. The individualized treatment plans included any psychiatric services, including psychotropic medications and the frequency of monitoring by the psychiatrist, when applicable. Four of the five reviewed youth were applicable for the completion of individualized treatment plan reviews every thirty days. Each of these youth had treatment plan reviews which were completed every thirty days, with one exception. One of the individualized treatment plan reviews was conducted one day late. The review of each youth's progress notes confirmed the youth received group, individual, and family counseling as specified in their individualized treatment plans.

Three closed records were reviewed for youth released from the program. There was evidence the program completed a Mental Health/Substance Abuse Discharge Summary in each reviewed record. These plans were discussed and finalized at the exit conference for each youth. Reviewed documentation confirmed these plans were signed by and provided to the parent/guardian of two of the youth at their time of release. The third youth was transported home through the Department's statewide transport system. The documentation in their closed record validated a copy of the Mental Health/Substance Abuse Discharge Summary being sent to this parent/guardian the same day of the youth's release. The mental health/substance abuse records, which include the Mental Health/Substance Abuse Discharge Summary, were sent to the juvenile probation officer (JPO) within five days of each youth's release from the program. The reviewed documentation also confirmed each youth received a copy of their Mental Health/Substance Abuse Discharge Summary in their exit portfolio, which was provided to them upon their release from the program.

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's contract with the Department requires them to provide services for borderline developmentally disabled (BDD) youth. A review of five youth mental health records confirmed the program completes a new Comprehensive Mental Health/Substance Abuse Bio-Psychosocial Evaluation for each youth within thirty calendar days of admission. This serves as their developmental evaluation. Additionally, mental health treatment planning begins the day of admission for each youth through the completion of an initial treatment plan. Each youth will then have an individualized treatment plan completed to address their developmental disability treatment needs no later than thirty-days after admission. Each youth's plan is individualized based on their identified needs. The review of progress note documentation reflected each youth receives daily developmental and psychosocial treatment through daily interventions and therapeutic activities. Progress note documentation validated group therapy is conducted seven days a week, individual counseling is done for each youth weekly, and family therapy is conducted at least monthly for each youth, at a minimum. All daily therapeutic activities are

conducted by the program's clinical care managers. Any youth with co-occurring disorders will receive substance abuse services through either group and/or individual counseling.

The program employ's a licensed clinical social worker (LCSW) who acts as the designated mental health clinician authority (DMHCA). They are on-site five days a week to provide oversight for all services provided. The contracted psychiatrist is on-site bi-weekly to perform psychiatric evaluations and to conduct medication management visits, as needed. The program also has a contract with Psychology Associates of Central Florida (PACF) for the provision of weekly services from a psychologist, and a contract with Applied Behavioral Learning Experiences to provide the services of a certified behavioral analyst (CBA). The review of sign-in and service documentation reflect both a psychologist and CBA provided services within the program weekly, with minor exceptions. A review of group progress notes, program schedules, and youth interviews confirm clinical staff are at the program seven days a week. None of the clinical care manager caseloads were found to exceed the contractual limit of seven youth.

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

The program has a contract with a licensed physician (MD) to provide psychiatric services. The psychiatrist's license is current and active, with an expiration date of January 31, 2020. Another MD serves as a back-up, and they also have a license which is clear and active, with an expiration date of January 31, 2020. A review of five records revealed two of the youth were admitted on psychiatric medications. The program was able to provide one more applicable record for review. Program practice is for each youth, regardless of whether they require psychotropic medications, to be referred to the psychiatrist for an initial diagnostic psychiatric interview. The review of five youth records confirmed each youth was seen by the psychiatrist within fourteen days of admission. Each initial psychiatric diagnostic interview was completed using the program's initial psychiatric evaluation form, which contained all required elements, and incorporated page three of the Department's Clinical Psychotropic Progress Note (CPPN) form. One additional youth in the sample was referred to the psychiatrist during their stay. They were seen within thirty days of the referral, and had a psychiatric evaluation completed by the psychiatrist which included page three of the CPPN. All required medication management appointments were completed monthly for each of the four applicable youth.

The program's contract to provide services to borderline developmentally disabled (BDD) intensive mental health requirements indicate the psychiatrist must be on-site bi-weekly to provide services to the youth. Their agreement with the program states they will provide services on a bi-weekly basis, and will be available twenty-four hours a day, seven days a week for consultation and emergencies. A review of psychiatric service logs found the psychiatrist was on-site every other week during the previous six-month period. Reviewed documentation supported there were no standing orders or emergency treatment orders for psychotropic medications. An interview with the psychiatrist validated they provide services bi-weekly and they are available for consultation twenty-four hours a day, seven days a week. He indicated there is good communication with the program, and they have a meeting with all available

clinical staff during each bi-weekly visit. The psychiatrist further indicated they have no concerns currently with the healthcare or other services provided 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 suicide prevention plan detailing the program's suicide prevention procedures. The plan outlines how the program will safely assess and protect youth with elevated risk of suicide in the least restrictive means possible. The plan includes identification and assessment of youth at risk of suicide, staff training, suicide precautions, level of supervision, referrals, communication, notification, documentation, immediate staff response, and a review process. All elements required by the Department's Administrative Rule were included in the plan. The plan was reviewed and signed by the facility administrator and the designated mental health clinician authority (DMHCA) on June 24, 2019 to meet the annual review requirement.

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

The program has a suicide prevention plan in place which outlines the methods used for supervising, observing, monitoring, and housing for youth identified through screenings, review of available information, or staff observations as having suicide risk factors. A review of five youth mental health and substance abuse records found each youth was screened for suicide ideation during their admission to the program. None of the five reviewed youth had a "hit" for suicide ideation on their Massachusetts Youth Screening Instrument – Second Version (MAYSI-2); however, it is program practice to conduct an Assessment of Suicide Risk (ASR) on each youth during the admission process, regardless of whether any suicide risk factors were identified. Each of the five youth were evaluated during admission, confirming the program's practice. Each of these youth had an ASR administered by a non-licensed clinician on the day of admission, and each were maintained on standard supervision. The review of the youth records revealed none of the five youth had any incidents of precautionary observation. The program had only one youth who had been on precautionary observation during the annual compliance review period. The provided record reflected the youth was identified as having suicide ideation during his admission screening. This youth had an ASR completed during their admission screening into the program. This youth was maintained on precautionary observation, and their supervision was documented on a Suicide Precautions Observation Log. These forms were completed in their entirety, to include the identification of "safe housing areas." The review of the ASR reflected notification was made to the youth's parent/guardian and their assigned

juvenile probation officer (JPO). The youth was seen for a Follow-up Assessment of Suicide Risk (FASR) the following day, and the decision was made to step them down to close supervision. The youth was subsequently stepped down to close supervision through the completion of a Mental Status Exam, per the program's policy. The documentation also reflected a conference with a licensed clinician, since the ASR was completed by a non-licensed clinician, and the executive director/designee prior to reducing the level of supervision in each instance. This was clearly documented on each reviewed form, and the DMHCA signed the form the next time they were on-site, when required. During this youth's heightened placement, their supervision was documented using Suicide Precaution Observation Logs and Close Supervision Logs. No lapses in supervision were seen on the reviewed logs. Documentation reflecting the placement status of the youth was found in the master control logbook, and in the Department's Juvenile Justice Information System (JJIS) alerts. All JJIS alerts for the one applicable youth were updated within one day, with the exception of the stepdown from close to standard supervision. This alert was not updated in JJIS until thirteen days after the status change was made.

The program does not use secure observation. The program has two suicide response kits in the master control area. Each kit was found to include a knife-for-life and needle nose pliers. They were both missing the required wire cutters. The program indicated they could use the wire cutters found on the included needle nose pliers. Even though they disagreed with the findings, they purchased wire cutters and placed them into each kit after being told of the discrepancy. Interviews were conducted with five staff regarding what they are responsible for if a youth expresses suicidal thoughts. All five indicated they would search the youth and room for sharp objects, place them on constant sight and sound, and would document their supervision. Four of the staff indicated they would notify mental health staff. The other respondent indicated they did not know who mental health staff are. The program's suicide prevention plan outlines an established review process for every serious suicide attempt or serious self-inflicted injury requiring hospitalization or medical attention. A representative from program administration and each department reviews the circumstances surrounding the event, program procedures relevant to the incident, relevant training received by involved staff, pertinent medical and mental health services involving the youth, possible precipitating factors, and any recommendations for changes in policy, training, physical plant, medical, or mental health services.

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

The review of five youth records found none of the youth had been placed on suicide precautions which required the completion of Suicide Precaution Observation Logs. The program only had one youth applicable for placement on suicide precautions during the annual compliance review period. There were three logs available for review for this youth. All logs were maintained for the duration the youth was on suicide precautions, and the staff documented the youth's behavior in real time at intervals which did not exceed thirty minutes. The youth exhibited warning signs while on precautionary observation, and these were documented on the back of the log, with the feedback which was provided by a clinician. Each of the reviewed Suicide Precaution Observation Logs also had all required reviews by supervisory staff and licensed clinicians. Clear instructions were provided for staff regarding

how each youth should be supervised. This was documented on a form which alerted staff to the specific type of supervision the youth was on, along with any restrictions which needed to be followed by those staff supervising the youth. An informal interview was conducted with the one youth who had been on suicide precautions during the annual compliance review period. The youth indicated staff were always with them during this placement, and they were never left alone while on suicide precautions.

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

The program has a suicide prevention plan which addresses suicide prevention training. A review of five staff pre-service and five in-service training records found each received at least six hours of suicide prevention training, which included two hours of training in the Department's Learning Management System (SkillPro) and four hours of instructor-led training. The program's mock suicide drills were reviewed since the last annual compliance review, which included the first three quarters of calendar year 2019. Each of the reviewed drills included the time of the drill, the designated shift, name of who conducted the drill, the nature of the incident, persons involved/function of each, type of medical care given, type of mental health/crisis intervention provided, the outcome of the incident, the time of response, and any follow-up or corrective action needed. The review found suicide prevention drills were completed all three quarters on all three shifts, without exception. All staff participated in at least one reviewed drill and any staff who were unable to attend a drill were given the opportunity to review the drill scenario during the monthly staff meetings. The drills during the first and third quarters of 2019 were all found to include a demonstration of cardio-pulmonary resuscitation (CPR). An interview with the facility administrator revealed the staff are provided training and mock drills in suicide prevention monthly.

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 crisis intervention plan which establishes the goal of responding to youth in crisis in the least restrictive method possible. This is done to protect the personal safety of the youth and others while maintaining control and safety of the program. The plan includes a notification and alert system, means of referral including youth self-referral, communication, supervision, and documentation and review of the crisis. All elements required by the Department's Rule were included in the plan. The plan was reviewed and signed by the facility administrator and the designated mental health clinician authority (DMHCA) on June 24, 2019 to meet the annual review requirement.

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.	

None of the five youth in the review sample had the need for a crisis assessment. The program was able to provide crisis assessment documentation for two different youth who required a crisis assessment during the annual compliance review period. One of these youth required two separate crisis assessments while at the program. In each instance, the youth were seen within two hours of being determined to be in crisis. Each assessment included the reason for the assessment, a mental status exam and interview, the determination of danger to self and/or others, clinical impressions, recommendations of treatment, supervision levels, and follow-up or further evaluation. Two of the youth were stepped down to standard supervision upon completion of the crisis assessment. In the third instance, the youth was maintained on mental health alert status after completion of their assessment. Their supervision was documented on a Mental Health Alert Log. The youth was stepped down to standard supervision after completion of a follow-up Mental Status Exam. The crisis intervention plan includes procedures for the notification of the youth's parent/guardian; and this was done in each of the reviewed assessments. All three assessments were either completed by a licensed clinician or a non-licensed clinician, followed by a review by a licensed clinician within the required twenty-four-hour period.

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

The program has a detailed emergency care plan which addresses mental health and substance abuse emergency care. The plan was reviewed and signed by the facility administrator and the designated mental health clinician authority (DMHCA) on June 24, 2019 to meet the annual review requirement. The plan contains all the required elements outlined in the Department's Rule and includes the immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment, transport for emergency substance abuse assessment and treatment, documentation, staff training, and program administration will review each incident.

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

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

Standard 4: Health Services

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

The program maintains an independent contractor agreement with a State of Florida physician to serve as the designated health authority (DHA) with an automatic annual renewal. The DHA holds an active, unrestricted license as an osteopathic physician with specialty training in internal medicine and a license expiration date of May 31, 2020. The program does not utilize an advance registered nurse practitioner/advance practice registered nurse or physician's assistant. The DHA is scheduled to be on-site weekly for approximately two hours, which was verified through a review of physician logs during the annual compliance review period. The DHA is responsible for communication with program staff regarding youth medical needs, and is available for consultation twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. The program has an active coverage agreement with a medical doctor, who has a clear and unrestricted license, signed June 21, 2018 in the event the DHA is not available. An interview with the DHA confirmed their role in the program.

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

The program maintains facility operating procedures (FOP) for all health-related procedures and protocols utilized. The program's assigned designated health authority (DHA) conducts an annual review of all health-related policies, procedures, and protocols. Reviewed documentation supported the DHA signed all healthcare policies and procedures on June 20, 2019, the facility administrator documented a review on June 17, 2019, and the psychiatrist documented a review on June 18, 2019. The program maintains one full-time registered nurse (RN), who also serves as the health services administrator (HSA). The program has utilized a traveling nurse and the Regional HSA, who both signed a cover page of the FOPs and nursing protocols on June 24, 2019 and June 30, 2019, to provide coverage as needed. The program maintains a nursing protocol manual developed and approved by the DHA on July 13, 2018. There were no new healthcare staff during the annual compliance review period.

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.	

A review of five youth individual healthcare records (IHCR) found one youth eighteen years of age or older and the applicable record reflected the youth signed a Release of Information form. The remaining four IHCRs contained a copy of a signed Authority for Evaluation and Treatment (AET) with the word "Copy" clearly stamped on each. There were no original AETs contained in the IHCRs reviewed. None of the five reviewed youth were in the custody of the Department of Children and Families (DCF). The program provided two additional records for youth in the custody of DCF with parental rights terminated to review. A court order to treat was found in each of the two youth's IHCRs. Each reviewed AET, Release of Information form, and court

order was filed in each youth's IHCR in the appropriate section. An interview with the nurse revealed the program attempts to obtain the AET prior to the youth's arrival and verify the signature. In addition, if a youth is over the age of eighteen at admission or turns eighteen, a consent is completed for treatment and release of medical information.

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

The program maintains a policy and procedures ensuring the parent/guardian is informed of significant changes in the youth's condition and to obtain consent when new medications and treatments are prescribed. Procedures also ensure the parent/guardian is notified to obtain consent of new psychotropic medications, discontinuances, or psychotropic medication adjustments. A review of five youth individual healthcare records (IHCR) supported four youth were applicable for parental consents and one youth was eighteen years of age or older and did not require consents. One youth record was applicable for parental notification of over-the-counter (OTC) medication beyond those covered by the Authority for Evaluation and Treatment (AET) and documentation supported parental notification was sent, utilizing the required Department form, and verbal consent was obtained with a witness. Two of the reviewed youth IHCRs were applicable for off-site care and reviewed documentation supported the parents/guardians were notified, as required. Nursing interviews indicated parents/guardians are mailed consents within twenty-four hours of the medical event. Verbal consent, when applicable, is obtained prior to treatment. Three of the five reviewed youth IHCRs supported the youth were prescribed a psychotropic medication and the required parent/guardian consents were obtained. Each of the three applicable IHCRs documented a telephone consent conducted by the psychiatrist and witnessed by the nurse on a Clinical Psychotropic Progress Note (CPPN) page three. A copy of the CPPN page three was mailed to the parent/guardian outlining the medication prescribed and reasons for the medication with the Acknowledgement of Receipt of Clinical Psychotropic Progress Note. Two youth were applicable for parent/guardian notification regarding updates to their chronic conditions after the Designated Health Authority (DHA) discontinued a condition for each youth which required a chronic clinic. Neither of the youth's parent/guardians were notified regarding the change in their medical status. Copies of all correspondence were maintained in the applicable youth IHCR. None of the five reviewed youth required immunizations; however, policy and procedures outline parental consent requirements to administer vaccinations and religious exemption requirements for parent/guardians who do not consent to vaccinations due to religious reasons. An interview with the nurse revealed the nurse will pull each youth's immunization record from the Florida Shots website within the first week of admission and have the designated health authority document a review of the record. None of the youth were applicable for being in the care of the Department of Children, Youth, and Families (DCF).

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

The program maintains a policy and procedures ensuring each youth receives a routine healthcare screening and evaluation upon admission and each time the physical custody of the youth changes and they are subsequently returned or readmitted. A review of five youth individual healthcare records (IHCR) validated each youth received an initial admission

screening utilizing the Department's Facility Entry Physical Health Screening (FEPHS) form. All admission screenings were completed by a registered nurse (RN). An interview with the health services administrator indicated a nursing assessment is conducted immediately following the initial search, normally within ten to fifteen minutes of the youth's arrival. The RN notifies the designated health authority (DHA) by telephone or verbally, if on-site, with the youth's history and identified chronic condition and documents the notification on the DHA Notification form and in the nursing admission chronological notes. The DHA Notification form is filed in the youth's IHCR in the practitioner's chronological note section. The program did not have any youth applicable for a change in custody during the annual compliance review period.

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

The program maintains a policy and procedures establishing a system whereby all youth shall be oriented to the healthcare system upon admission. The health education shall be provided by the healthcare staff, in writing and during an individual session with the youth to ensure youth with identified disabilities can understand the information provided. A review of five youth individual healthcare records (IHCR) validated each youth received a healthcare orientation on the day of admission, as documented on the Department's Health Education Record form. Each youth received a health education packet specifically designed for male adolescents including access to medical care, sick call, what constitutes as an emergency, medication process to include side effect monitoring, the right to refuse and how it is documented, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the health care providers. Youth and nursing staff signed the health education packet acknowledging the training was conducted and the youth reviewed and understood the information. In addition to the admission health orientation, youth received health education each month on different topics which was documented in each youth's IHCR.

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

Five youth individual healthcare records (IHCR) were reviewed and each validated the designated health authority (DHA) was notified by telephone and the Notification of Admission form was filed in the practitioner's section of the IHCR. In addition, the nurse documented the DHA notification on the Nursing Chronological/Notification Progress Note – Male Admission form and the filed the form in the nursing chronological notes section of the IHCR. The nursing staff updated the Chronic Conditions Log after the notification was completed, if necessary. No youth were identified as in-need of an emergency response at admission.

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

The program maintains a policy and procedures ensuring nursing staff shall complete the Department's Health-Related History (HRH) form prior to the Comprehensive Physical Assessment (CPA). A review of five youth individual healthcare records (IHCR) found a new

HRH form completed the same day of admission. The nursing staff provided their signature on the HRH form with the exception of one HRH form which was missing a signature; however, all other information was completed. The DHA documented a review of each HRH form on the completed CPA in each of the five youth IHCRs reviewed. An interview with nursing staff validated the practice and indicated the HRH form is also completed whenever there are significant changes or medical events and annually.

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

A review of five youth individual healthcare records (IHCR) validated each record contained a completed Department Comprehensive Physical Assessment (CPA). Each of the CPAs were new and completed by the designated health authority (DHA) within the required timeframe. All CPAs were completed in their entirety and the Department's Problem List was reviewed and updated, if necessary. Each CPA was completed in accordance with the Department's Rule. All five CPAs documented the clinician deferred the genital exam; four youth CPAs stated "deferred, negative history" and one youth CPA stated, "deferred by clinician, due to negative history." All five youth had at least one verified tuberculin skin test (TST) completed within the last year and documented on the Infectious and Communicable Disease form. No youth required a chest x-ray or follow-up treatment based on the results of the TST. An interview with the nurse indicated the nurse reviews the youth's previous medical records to determine if a new TST is needed and ensures the DHA completes the CPA within the required seven-day timeframe.

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

The program maintains a policy and procedures ensuring all youth admitted shall be clinically screened and medically evaluated for sexually transmitted infections (STI). The designated health authority (DHA) shall then decide based on the screening tool and medical evaluation to order testing for sexually transmitted diseases/infections. A review of five youth healthcare records found each youth was identified as sexually active and was clinically screened and evaluated for STIs utilizing the Sexually Transmitted Infectious Screening form. One youth was referred for further evaluation; however, the youth did not receive testing. There were no applicable youth who were out of the Department's custody for over thirty days and/or required a rescreening. An interview with the nurse validated the practice.

The program maintains a policy and procedures ensuring all youth at risk for human immunodeficiency virus (HIV) infection are offered counseling, testing, education, prevention counseling, and a referral for medical treatment, as indicated. A review of five youth healthcare records validated each youth was offered the opportunity to receive counseling and testing for HIV. The program utilizes a site-specific HIV Risk Assessment and a referral for testing is based on the assessment results. The program utilizes on-site testing by the health services administrator (HSA) to provide pre-counseling, testing, and post-counseling. The HSA maintained a current certificate of registration with the Florida Department of Health to conduct HIV testing. None of the five reviewed youth records indicated the youth consented for HIV testing. The program reported no youth have consented for testing during the annual

compliance review period. An interview with the HSA verified the process and reported any testing and education would be documented on the Health Education Record and the HIV assessment. Five youth were interviewed and each reported they can request and receive an HIV test.

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

The program offers sick call five days a week, once daily, and conducted by the registered nurse (RN) who is also the health services administrator (HSA). A program tour revealed the program maintains sick call forms on the wall of each dorm accessible to youth and a sick call box for youth to place completed request forms in. The HSA checks the box daily and if the HSA is not on-site, the supervisor reviews request forms to ensure youth needs are met. A review of five youth individual healthcare records (IHCR) found two youth completed a Sick Call Request form during the annual compliance review period. One youth submitted two separate sick call request forms. Each of the three sick calls were missing the original sick call from completed by the youth; however, and electronic version of the form with the youth's complaint transcribed on the form was found in each youth's IHCR. The registered nurse (RN) documented the treatment and/or services provided to the youth during the sick call event on the Sick Call Request form and the incidents were documented on the youth's Sick Call Index. There were no applicable youth who presented a similar sick call complaint three or more times within a two-week period. Each of the three sick calls were found on the Sick Call Log and were completed by the HSA, as required. There were no sick calls to observe during the annual compliance review. Five staff interviews were conducted, and each reported the nurse conducts sick call and one reported the designated health authority (DHA) will also conduct sick call. Five youth were interviewed, and each youth reported they are seen within one day if they submit a sick call.

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

A review of five youth individual healthcare records (IHCR) found four of the youth required episodic and/or first aid care during the annual compliance review period. All treatment services were provided by the nurse and the nursing progress notes clearly documented treatment services rendered in standard narrative charting. The nurse also maintained an Episodic/First Aid/Emergency Care Log documenting all incidents of care by date, name of youth, Department identification number, injury/emergency, treatment rendered, registered nurse initials, and whether the youth was referred to the designated health authority (DHA). Each of the four reviewed incidents of episodic/first aid care were found on the Episodic Care Log. An interview with the nurse validated this practice. A review of the Episodic/First Aid/Emergency Care log found no instances in which a non-licensed staff provided episodic care during the annual compliance review period. The five reviewed IHCRs contained two instances of off-site care which were each found on the log, as required.

The program maintains an automated external defibrillator (AED) located in the administration hallway mounted to the wall. Nursing staff ensure the AED is functioning adequately and include

the inspection of the batteries and pads to ensure they are in working order. The AED procedures were observed as written and audio as demonstrated by the nursing staff. Reviewed AED batteries expire on January 2024 and were last changed on September 30, 2018. The AED pads expire in November 2019 and were last changed in September 2019. The program maintains four first aid kits located in medical and master control and two additional kits stored in master control for the two program vans. Each of the first aid kits were reviewed and found to contain only DHA-approved contents. One first aid kit contained expired hand sanitizer August 2019. The program also maintains one suicide response kit located in master control containing a knife-for-life, and needle nose pliers which has a wire cutter built in; however, the program purchased wire cutters while the review team was on-site. The first aid kits, AED, and suicide response kits are checked monthly by the nurse to ensure they are adequately supplied and in working order.

Five pre-service and five in-service staff training records were reviewed and supported all non-healthcare staff who have direct contact with youth maintained current certifications in first aid, cardiopulmonary resuscitation (CPR), and AED. The nurse also maintained current certifications in CPR and AED. In addition, the reviewed training records supported staff supervisors have been trained in the administration of the epinephrine auto injector and assistance of medication administration. The program conducts announced and unannounced emergency medical drills monthly on each shift. Reviewed drills supported an annual calendar is maintained identifying the drill conducted. A review of drills conducted for the last twelve months supported drills were conducted monthly on each shift and included CPR/AED demonstration at least quarterly. One drill dated August 16, 2019 was missing signatures of participants. Observations made during the program tour found postings throughout the facility informing staff of their right and responsibility to call 9-1-1. Emergency telephone numbers were located in master control and the medical clinic inaccessible to youth, including the number to Poison Control.

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

The program maintains a policy and procedures ensuring for timely referrals and coordination of medical services to an off-site healthcare provider. Evaluations conducted offsite shall be recorded on the Department's Summary of Off-Site Care Form. The designated health authority (DHA) reviews, signs, and dates the off-site care instructions. A review of five youth individual healthcare records (IHCR) found two youth requiring off-site care and/or emergency care. Each youth off-site care event was documented in their healthcare record. The two reviewed youth were under eighteen years of age and there was documentation in their IHCR indicating the parent/guardian was notified. The Summary of Off-Site Care Form was completed for each youth and was filed in the appropriate section of the healthcare record. Reviewed documentation supported the DHA reviewed each completed Summary of Off-Site Care Form as evidenced by signature and date. Both youth required follow-up care, and each received services as prescribed. An interview with the nurse indicated the registered nurse tracks follow-up testing by using the nursing calendar. The nurse places all off-site care findings, instructions, and information in the DHA folder for review and documentation of signature, in addition to documentation flagged in the IHCR.

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

A review of five youth healthcare records indicated two youth were admitted with an identified chronic condition as documented on the Facility Entry Physical Health Screening (FEPHS) form. One additional record was provided for review of chronic care. The program maintains a youth roster of youth requiring periodic evaluations identifying the youth's name, date of admission, whether youth was admitted with prescribed medication, chronic condition, date of last visit, and next visit date. Reviewed records supported each youth received periodic care from the designated health authority (DHA); however, the care was not always documented as a periodic evaluation. One youth was found to have been taken off a protocol for obesity, as ordered by the designated health authority (DHA). Even though the youth was not on a protocol for obesity, the youth was seen by the DHA within the required timeframe. In addition, the youth had a chronic condition (allergic rhinitis) resolved by DHA; however, the Department problem list was not updated. There was also no documentation the parent/guardian was involved in or notified of the change in the youth's chronic condition. Another youth was originally identified with asthma and the DHA discontinued the diagnosis based on the youth not requiring recent treatment; however, the parent/guardian was not involved in or notified of the change. An interview with the nurse indicated once a youth is identified with a chronic condition upon intake or by the DHA they are placed on the medical tracker for monitoring. The psychiatrist indicated the youth on psychotropic medications are evaluated every thirty days. There was no indication of missed periodic evaluations. Reviewed documentation supported each youth receives a new Comprehensive Physical Assessment (CPA) within seven days of their admission. The DHA diagnoses or confirms the chronic condition and prescribes the youth a treatment plan. Approximately every sixty days the DHA conducts a periodic examination of the youth, and if applicable, continues the youth on the specialized treatment plan and/or modifies the plan. An interview with the facility administrator revealed daily morning management meetings, psychiatric meetings with the clinical team, and all-staff meetings are utilized to review important medical issues pertaining to youth in the program.

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

A review of five youth individual healthcare records (IHCR) indicated four youth were admitted into the program on prescribed medication. The nursing admission note in each youth's IHCR documented the youth's current medication and notification to the designated health authority (DHA) and/or psychiatrist. There was documentation the DHA or psychiatrist resumed the prescribed medication for the youth in each youth IHCR. Reviewed Medication Administration Records (MARs) validated the practice. Each medication was verified by the nurse upon the youth's admission and documented in the youth's IHCR.

Reviewed documentation supported all medications had a current, valid order, and were given pursuant to a current practitioner's order. The program does not utilize restrictive housing, which was verified through an interview with the nurse. The nurse also reported if a youth were to be placed in isolation, the nurse would make a daily visit to the youth in addition to providing all normally scheduled medications. Each reviewed youth IHCR indicated each time a prescribed

medication was continued, discontinued, changed, or a new medication was ordered, the practitioner's order clearly documented the medication and dosage. All four reviewed youth applicable for medications had documentation the program utilizes a pre-printed MAR to document administration of medication. Each reviewed MAR documented the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade, and a current picture of the youth. All four youth were taking prescribed medications upon admission and the initial MAR matched the medication listed. The youth's MAR and/or Individual Controlled Medication Inventory Record is updated after each administration. All four reviewed MARs supported the youth received the medications, as prescribed. The MAR clearly indicated medication start and stop dates. Two youth MARs did not have the same medical grade as listed on the program's alert log. Licensed staff initialed the MAR for each administered medication entry. In the event non-licensed staff assisted youth in the administration of medication, both the staff and youth initialed the MAR as required. There were no indications of lapses and/or errors in the medication administration. A review of the Department's Central Communications Center reports validated there were no incidents of missed medications. Nursing staff documented side effect monitoring on the MAR daily each time medication was administered.

A review of staff training records found each non-licensed staff who administered medication during the annual compliance review were trained in assisting youth with the administration of medications. Training was conducted by the health services administrator (HSA). The program maintains one refrigerator in the medical clinic for the storage of medication. There were no applicable medications requiring refrigeration during the annual compliance review. Five youth interviews were conducted and four reported the nurse gives them medication while one youth reported they do not take medication. Each of the four youth on medication described the process as the nurse provides medication after the youth states their name, the medication is crushed, and then after the youth take the medication their mouth is checked to ensure they swallowed the medication.

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

The program maintains all medications securely stored in the medical clinic, inaccessible to youth. An observation of the medical clinic found all non-controlled medications were stored in a separate, secure, locked medication cart and over-the-counter (OTC) medications were placed in the top drawer of the locked medication cart. Narcotics and other controlled medications are securely stored in the medication cart inside a locked box. Oral medications were not stored with injectable or topical medications. The program maintains one refrigerator for medications. There were no medications requiring refrigeration during the annual compliance review. The program securely stored sharps and syringes separate from medications. Reviewed documentation and nursing interviews confirm all OTC medications are inventoried at least weekly. Program practice is for OTC medications to be inventoried using a perpetual inventory daily and verified weekly. Perpetual inventories with running balances are maintained on all controlled substance logs; however, shift-to-shift counts of controlled medications, with the nurse and a witness, were not completed during the annual compliance review period. Syringes and sharps are counted through a perpetual inventory and are verified weekly.

The program contracts with a pharmacy and a State of Florida licensed consultant pharmacist. Reviewed documentation supported the consultant pharmacist conducted monthly on-site inspections and maintained a consultant pharmacist inspection log and consultant pharmacist monthly inspection report. Reviewed documentation supported the consultant pharmacist conducted a quarterly interdisciplinary risk reduction quality improvement process with the facility administrator and registered nursing staff. The program maintains a policy and procedures for the disposal of narcotics and other controlled substances. Program practice is for the consultant pharmacist and registered nurse to dispose of the medication by placing the medication in a RX Destroyer and document the disposal on the Disposal Log and on the Controlled Medication Inventory Record. Three youth prescribed medications, three OTC medications, and three sharps were counted during the annual compliance review and each were found to match their corresponding inventories. A review of the program's counts from the past six months validated no discrepancies were identified with the counts. The program maintains a current agreement with Stericycle, Inc. for biomedical waste. Stericycle, Inc. picks up medical waste monthly. An interview with the health services administrator (HSA) confirmed the inventory and medical disposal processes.

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

The program maintains a policy and procedures ensuring there is an approved plan for exposure control and infection control ensuring staff, youth, volunteers, and visitors are not exposed to infectious and communicable diseases. The program's Exposure Control Plan/Infection Control Plan includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the guidelines and recommendations of the Centers for Disease Control and Prevention (CDC), Occupational Safety and Health Administration (OSHA) federal regulations, and State of Florida guidelines. The plan was reviewed and approved by the facility administrator (FA) on June 17, 2019 and the designated health authority (DHA) on June 20, 2019. The plan includes common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, and tuberculosis. In addition, the plan includes Hepatitis A, B, C, and human immunodeficiency virus (HIV) infectious diseases caused by blood-borne pathogens. The plan outlines outbreaks in pediculosis and/or scabies, outbreaks or epidemics caused by other infectious agents, foodborne illnesses, bio-terrorists' agents, chemical exposures, Methicillin-Resistant Staphylococcus Aureus (MRSA), and other emerging antibiotic-resistant micro-organisms. The program maintains procedures for staff to adhere to universal precautions, and the program provides staff with the opportunity for Hepatitis B immunizations and access to protective equipment. The program also maintains a written biomedical waste plan for staff to utilize for any threat of infection due to solid waste or liquid waste which may present a threat of infection to humans. The program maintains monthly receipts of medical waste pick-up through a contracted provider, Stericycle, Inc. The program had no instances in which the Hillsborough County Health Department, CDC, and/or the Department's Central Communications Center (CCC) should have been notified of an infectious disease. The program's plan has a comprehensive process for needle stick post-exposure evaluation. In the event of an incident,

the facility administrator has a process in place to establish a separate file containing all documents for youth and staff who have experienced a facility/occupational exposure. The program's Exposure Control Plan/Infection Control Plan is written in accordance with OSHA standards. The plan includes risk assessment and methods of compliance.

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

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

Standard 5: Safety and Security

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

The program has policy and procedures addressing youth supervision. The staff to youth ratio is one to seven program-wide, which includes direct care staff, supervisors and administration. The program was in compliance with the staff to youth ratio each day of the annual compliance review. Observations included youth activities while dining, in the classroom, in the dormitory, in the common area, during youth movement, at recreation, during transportation off-site, and work details. Staff exercised appropriate positioning and kept youth within sight at all times. The review team did not observe youth unsupervised during the annual compliance review. Youth were consistently escorted by staff when transitioning one at a time or in larger groups. The daily schedule was posted in prominent areas of the facility. Observations confirmed the program followed the posted schedule.

Informal staff interviews consistently revealed they were able to account for the number of youth being supervised. Five staff were formally interviewed regarding the process if counts cannot be reconciled. Each staff reported movement is stopped when a count is off and the count is conducted again. Two staff mentioned if the count is off, youth will be sent to their room for the count and another staff discussed staff searching additional areas of the program if a youth cannot be found during the recount.

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

The program has policy and procedures addressing the comprehensive and consistent implementation of the behavior management system (BMS) and staff training. Five pre-service training records were reviewed and each received training in the BMS as required by the program’s contract. The program provided documentation the school board and the program agreed on the program’s BMS. Informal staff interviews revealed educational staff are in charge of education in the classroom while program staff support the school utilizing the BMS.

The BMS includes a token economy in which youth earn points for each activity of the day and convert the points earned into purchases at the canteen, increased responsibility, and gained privileges. Youth not earning the required points for the day/week/month lose the privilege of participation in extra incentives. The BMS includes multiple levels were youth earn the next level to attain increased privileges and responsibility at each advanced stage in the system. Since the

last annual compliance review, there have been no modifications to the BMS; however, the BMS included a level freeze process not described in the policy and procedures. The level freeze process was found to be outlined in the youth handbook; however, the process of removing a youth from the level freeze was not described. Informal staff interviews revealed some youth had been on level freezes for numerous weeks and appeared to be frustrated in maintaining sufficient behavioral change to get off the freeze. The contracted Board Certified Behavioral Analyst (BCBA) was consulted and drafted a program-wide implementation of some new incentives to ensure effective implementation. Additional incentives have been introduced to motivate youth such as: mega Monday where youth completing a weekend with all earned points participate in a party where they get to view a movie and eat special food, and a perfect day incentive where one perfect point card day equals a total of three days toward the level freeze. Youth responded well to the new incentives and most have worked off the lengthy level freezes. An interview with the designated mental health clinical authority (DMHCA) clarified each level freeze is individualized for each youth in their special treatment team (STT) meeting. Referral forms are completed with the youth during the meeting in which the youth signs off on the form, acknowledging they understand the requirements of their level freeze. Level freeze, by function, does not extend the youth's time in the program. If a youth receives level freeze for a major behavioral violation, it is understood the youth is not meeting their performance plan goals as they are in the pre-contemplation or contemplation stage of change.

Five staff were interviewed regarding positive reinforcements in the BMS. Staff listed the program offers daily incentives in which youth can participate in a special activity, which includes an extra snack or food item, if the youth make their daily points. Individually earned points can be spent at the canteen, mostly for snack and food items. Youth who earn their day/week/month are allowed to participate in the group incentive such as mega Monday, weekly off-campus outings, attending a ball game, or movies. One staff clarified there is a list on the dorm which says what items youth can get from the canteen with their points such as snacks, notepads, or extra phone time. Another staff described some group activities for youth earning the incentive includes movie night, pizza parties, off-site outings, additional outdoor activity, earning items like composition notebooks, a later bed time, and the ability to work toward moving up to the next level in the BMS. All five staff indicated nothing can be taken away from youth as consequences. An interview with the facility administrator confirmed the BMS practices.

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 has a policy and procedures addressing behavior management system (BMS) infractions and system monitoring. The program has one assigned staff, who is assisted by the recreation therapist, to total the point cards daily and post the results after 3:00 p.m. The points are monitored by administration and the treatment team who use the documents to verify

behavior qualifying a youth to advance in the level system. The program has a process in place to ensure staff are evaluated based on their use of the BMS during performance evaluations. A review of five pre-service and five in-service staff records found each staff's record included a signed position description, which included outlining their responsibilities regarding the BMS. The records also included a recent performance evaluation in which they were rated in their use of the BMS. An interview with the facility administrator confirmed the point cards are reviewed by the community case manager and special treatment team reports are reviewed in the morning management meeting. In addition, the BMS utilization is reviewed during meetings, when needed, and during performance evaluations.

Five youth were interviewed regarding the use of rewards and consequences. The youth described the consequences as level freezes, incentive freezes for seven, fourteen and twenty-one days, work details, scrubbing walls, picking up trash, basic cleaning, and losing the privilege of the daily incentive. All five youth indicated youth are never allowed to punish other youth. The youth described rewards as the daily incentive, extra snacks, relay races, bean bag toss, mega Monday, participation in movie night and raffle tickets, throw down Thursday, special food/dinner, opportunity to spend points earned in the canteen, choosing a special picture to hang on your dorm wall, the monthly raffle for an outside purchased meal, and the end-of-the-month movie party with food for those who made the month positively. The youth were also questioned regarding staff consistency on use of rewards. Three youth identified the key staff who ensure the point cards are completed fairly. Two youth indicated if you make your points you make your day. One of these two indicated they are handed out fairly. Other comments included the point cards identify youth on a freeze who cannot get the daily incentive while another youth indicated everyone has an equal chance to earn raffle tickets and get points on their card. One other youth commented on one day he got a zero and did not think he should have been graded so severely. Four of the youth rated the BMS very good and one youth rated it good.

Five staff were interviewed regarding how youth are informed of consequences and if youth are able to explain their behaviors. The staff reported the treatment team will tell the youth about consequences and youth can explain to treatment team what happened. If staff write a referral, the youth is given the referral to sign and can discuss their behaviors with staff. At end of day the case manager calculates points and gives supervisor/staff results. Staff tell youth at the time of daily incentive if they did or didn't make their day. The staff were also interviewed regarding how supervisors inform them of feedback on use of behavior management system. Two staff reported feedback is giving during morning and monthly staff meetings, two staff responded if something is not being done correctly, the supervisor will pull the staff aside and counsel them one-on-one to ensure the consequences and rewards are fair, and one staff indicated staff are given feedback randomly, or in morning debriefings.

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

The program has a policy and procedures addressing ten-minute checks. The program has twenty-seven cameras and has the capacity for retaining thirty days of video. During the video review, the system indicated there were thirty-one days of memory available and all twenty-

seven cameras were in good working order. A review of six different shifts, each for one hour, was conducted to monitor ten-minute checks. All three shifts were included in the video reviewed. All reviewed checks were completed within the ten-minute window and most were completed eight minutes apart. The video appeared to be one minute off from the documented checks; however, checks were completed and documented at the correct intervals. One hour of checks on one reviewed shift was not recorded in real time. Five staff were interviewed regarding the frequency of room checks when youth are in sleeping, two staff indicated every ten minutes, four staff indicated counts are conducted every eight minutes. The staff also indicated the shift supervisor verbally prompts staff over the portable radio to begin checks every eight minutes.

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

The program has a policy and procedures addressing census, counts, and tracking. Procedures outline counts are conducted at the beginning and end of each shift, after outside activity, and after emergency events, or when a youth cannot be located. A review of logbooks maintained during the annual compliance review period documented counts at the beginning and end of each shift and scheduled and unscheduled counts throughout the shift. Counts were also documented following emergency events such as fire and evacuation drills, and following movement. Counts were reconciled following admissions and releases, and in relation to departure and return from transport. During the review of the logbooks, youth were documented as going outside nine of the twenty-one reviewed days for recreation. There was no logbook documentation indicating a youth count was conducted following outside recreation. Further, the team reviewed video of recreation of one day during the annual compliance review and there was no count documented following youth return inside the dorm.

Five staff were interviewed regarding how and when youth counts are conducted and what happens when there is a discrepancy such as an emergency. Staff indicated counts occur every hour, during three scheduled counts per shift, some scheduled and some unscheduled, and before/after movements. The count is called into the supervisor/master control who controls movement until after the count is completed if there's a discrepancy or we think a youth is missing, we count again; if youth are counted again and there is still a discrepancy several staff indicated different actions. Youth are put in their rooms and count again; or all movement stops, count again, and search bathrooms and offices; and all youth will stand by their door and the staff see who's missing from their door to identify youth.

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.	

The program has a policy and procedures addressing logbook entries and shift report review which includes the program solely utilizing a central logbook. A review of logbooks maintained during the annual compliance review period found the logbooks were bound with numbered pages and documented in black or blue ink with entries including the date/time of entry and the staff name included at the end of the entry. Logbooks included emergency situations, incidents, special instructions for supervision and monitoring of youth, population counts at the beginning and end of each shift and any other population counts conducted during a shift, perimeter security checks, transports away from the facility, and admissions and releases. Logbooks consistently documented times law enforcement came on-site. There was occasional overwriting, instead of staff crossing out with a single line and initialing indicating a change. One entry appears to be documented after the shift was closed out, as indicated by the entry coming after a diagonal line; however, it was not labeled as a late entry. All required information, incidents, Central Communications Center reports, and Florida Abuse Hotline reports were documented in the logbook as required. One incident documented a youth was placed in mechanical restraints; however, there was no specific information regarding the use of mechanical restraints. The central logbook is used to pass information, which is maintained at Master Control. Incoming staff sign they have reviewed the logbook and previous shifts prior to beginning their shift in order to ensure information is disseminated.

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 addressing key control. The procedures include key assignment and usage restrictions, inventory and tracking, secure storage of keys not in use, missing or lost keys, and reporting and replacement of damaged keys. Interviews with the facility administrator indicated there had been no lost keys during the annual compliance review period. Damaged keys are replaced by a contracted key vendor. The program maintains a key binder which identifies each key in the facility by number/stamp on the key. The program also issues permanent issue key rings to specific staff. Each of the permanent issued key rings were signed out to the identified staff including the total number of keys on the ring and the individual key type. Daily issue key rings were identified by ring number and listed each key type on the ring. The binder also contained blank copies of the form for missing or damaged keys. A review of three key rings reviewed randomly included two rings for daily issue and one permanent issued key ring. The review revealed two of the three contained the identified keys on the ring. The key binder indicated one of the key rings had ten keys; however, a review of the key ring

revealed it contained thirteen keys. Administration performed an immediate review and updated the master key inventory to reflect the correct number of keys assigned to the key ring. Five staff were interviewed regarding key control procedures and the staff reported staff and visitor personal keys are given to master control upon entry and securely stored, a chit or token is provided to visitors, and issuance of staff keys are tracked daily using a key log as keys are assigned to staff. The staff also reported if keys are missing or damaged, the program notifies the Central Communications Center (CCC), staff call the supervisor, and the supervisor notifies maintenance. If the keys were missing, the youth would get searched and staff are to immediately report the missing keys.

5.08 Contraband Procedure	Satisfactory Compliance

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

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

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

The program has a policy and procedures addressing control of contraband. The program clearly defined what was considered contraband and included the list in the youth handbook and in the letter to the parent/guardian at admission. The list included the forbidden items such as sharps, escape paraphernalia, tobacco products, electronic or vaporless cigarettes non-facility issued electronic equipment or devices, metals, personal cellular devices, unauthorized currency or coins and on-facility issued keys. Procedures also included consequences for staff introduction of the forbidden contraband items and involvement of law enforcement if illegal items or unlawful activity were involved. The prohibition of contraband and possible consequences was posted in a prominent area of the entrance hallway. The program maintains a search binder documenting the rooms/dorms searched and organized by months. The program documented thirty-one searches in May, twenty-three in June, fifteen in July, twenty-seven in August, and fourteen searches in September. Each page of searches identified the room and the items found. None of the findings included illegal contraband requiring notification of law enforcement. Most of the findings included items such as extra clothing, snacks, pencils, food wrapper, extra toothbrush, fork, playing cards, DVD, bottle, hair brush, extra pillow, staples, paper clips, toothpaste, grease, extra mat, and extra blanket. An interview with the facility administrator revealed staff documented searches on a room search form. Each of the forms are documented on the monthly contraband log. Any found contraband is disposed of by the assistant facility administrator or facility administrator.

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

The program has a policy and procedures addressing searches and full body visual searches. Procedures include all youth receive a full body visual search in a private area by two staff of the same gender upon admission. Procedures also call for youth to be searched following engagement in outdoor activities and upon returning from program supervised activities away from the program. Additionally, youth are to be searched and searched with an electronic search device after vocational or work projects involving the use of tools. Searches were observed throughout the annual compliance review before and after a transportation and following movements. Five staff were interviewed regarding when and how youth searches are conducted. All five staff indicated youth receive a visual/frisk search after every movement, three staff indicated youth are searched when they come back from being off-site, one staff indicated youth are searched whenever youth go outside and come back in, and another staff indicated youth are searched when an item goes missing. Five youth were interviewed regarding when searches occur, and each indicated they are searched when returning from off-campus, after outdoor activities, when items are missing, and after visitation. Two youth indicated they were also searched after meals and at other times and one youth indicated sometimes staff check us after recreation. The youth related a situation in which a new staff said they needed to search youth and the youth informed staff they were not searched every day after recreation. Observed activities during the annual compliance review and a review of program video during recreation activities confirmed youth were not searched following recreation on September 30, 2019 and following an occasion on campus when youth were working with landscaping tools September 10, 2019.

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

The program has a policy and procedures addressing vehicles and maintenance. The program maintains two vehicles for transportation. Informal staff interviews revealed one of the vehicles is not used to transport youth due to its physical condition; however, documentation revealed both of the vehicles received regular maintenance and passed an annual inspection from a professional maintenance company. The program maintained receipts for maintenance and annual inspections in a central binder. A visual review of both of the vehicles revealed each contained working seatbelts for each seating position in the vehicle, fire extinguisher (with current inspection), and seat-belt cutter/window punch tool. Although the program is for non-secure youth, the program is equipped with a secure cage in each van. The doors on the youth section of the van were unable to be unlocked from the inside. The doors of the two vehicles were consistently locked during the review week. Random checks of vehicles in the parking lot revealed most of the staff/visitor vehicles were consistently locked. On two occasions during the annual compliance review, an unlocked vehicle was found; one was discovered by the staff perimeter check and one was discovered by an annual compliance review team member. Both

the staff involved were located and the vehicles were locked. The program maintains stocked first-aid kits stored inside the facility for transports and a facility-issued cellular phone for the drivers. A transport was able to be observed and confirmed staff and youth wore seatbelts during the transport.

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

The program has a policy and procedures addressing transportation of youth. Procedures include staff of the same gender of the youth must accompany youth on transports. Procedures also detail the required ratio of staff to youth for off campus transportation as one staff to five youth. Staff remove the first aid kit from the vehicle after each use and take a replenished first aid kit on each trip. Each first aid kit contained the required elements and was sealed with a zip tie. Staff escorts for trips are issued a company cell phone. The program logbook consistently documented the staff and youth taking trips off-campus. The program documented monthly driver's license checks during the annual compliance review period. Five staff were interviewed and each confirmed they use a cell phone provided by the program during transports. All five staff also indicated staff are not allowed to use personal vehicles to transport youth. One transportation was able to be observed in which staff transported youth off-campus. Staff searched the vehicle prior to the trip and filled out the documentation. Staff took a program-issued cell phone and first aid kit with them. Staff unlocked the vehicle and assisted the youth into the van. Staff ensured the youth buckled the seat belt. Staff loaded into the van and buckled their seat belts and departed. The team was not able to observe a transport returning to the program.

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

The program has a policy and procedures addressing weekly safety and security audit. The program completes a weekly Facility Security Audit and Safety Inspection consistently listing deficiencies on the back page. A member of administration completed the weekly audit for the last several months since the maintenance staff resigned. A comparison of the deficiencies on the weekly audit with the work orders revealed deficiencies were regularly closed. An interview with the facility administrator revealed the safety and security deficiencies are discussed and tracked through the monthly safety team meetings, daily morning management meetings, all staff meetings, and supervisor meetings.

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 addressing tool inventory and management. The only tools on campus are class B tools which are securely stored in the laundry room. Staff inventory all class B tools on the daily housekeeping log. A review of the daily housekeeping log revealed it was consistently completed each day including the inventory of mops, brooms, and scrub brushes. Five youth records were reviewed and each youth received education on the use of tools at orientation, in addition to monthly risk assessments during the treatment team meetings.

Five staff pre-service training records were reviewed and each received training in the use of tools at the program.

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 addressing youth tool handling and management. The program completed risk assessments for youth monthly with a space on the assessment for use of class B and class A tools. A review of five youth records revealed each youth had received the monthly risk assessment including tools, as required. The assessments were completed during the monthly treatment team meetings. Five staff were interviewed regarding youth use of tools and each indicated youth are allowed to use mops and brooms. Four of five staff indicated youth are also allowed to use scrub brushes. Five youth were interviewed regarding the use of tools and each indicated they use mops and brooms. Three youth also indicated they use scrub brushes and rakes. Four youth expanded further on the use of tools during work details in which three of the youth included hedge clippers in the tools allowed to use, two included paint brushes, and two indicated the use of rakes. One youth indicated they have to be on level of all-star to use a rake. The review team followed-up with the program on the youth reports of utilizing class A tools, including the hedge clippers. The program reported one of the teachers, who is also contracted to complete yard maintenance, brings in their own tools and allows youth to use tools while instructing them on agriculture and landscaping, under the supervision of direct care staff. Each youth who reported using hedge trimmers was found to have updated risk assessments to utilize tools. An incident of work detail involving the use of class A tools brought into the program was observed by video and found youth were supervised by staff in the appropriate ratio of one staff to five youth.

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 addressing outside contractors. The program maintains a binder containing sign-in sheets with space for tool inventory of outside contractors. The binder contained numerous sheets for contractors, including trades such as pest control, electrician, camera repair, and installation crew which matched the record of invoices provided by the program. The annual compliance review team observed, on video recording, youth and staff using yard tools; however, these sign-in sheets were not in the binder. The program provided the sign-in sheets for the landscaping crew along with the invoice for these services after they were requested. Staff interviews indicated teaching staff bring landscaping tools on campus as this person performs landscaping duties at this program and the sister program on the same property.

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 has a policy and procedures addressing fire, safety, and evacuation drills. Fire drills were done on each shift each month of the annual compliance review period. The program

conducted at least one additional Disaster and Continuity of Operations Planning (COOP) drill on each shift each month during the annual compliance review period. COOP drills included fire, thunder/lightning, heavy weather/wind, gang/riot, hostage, chemical spill, power outage, flooding, and fight/altercation. The program maintained an evacuation binder containing an identification sheet for each youth including a color photograph, and all required data. The binder was maintained in master control for easy retrieval in the event of an emergency. An interview with the facility administrator indicated the following drills are completed: fire drills on each shift monthly, medical drills on each shift monthly, COOP drills on each shift monthly, and clinical mental health drills each shift quarterly. Drill documentation consistently included the time the drill began and ended, staff involved, and a critique of the drill. Five youth were interviewed regarding instructions in and frequency of fire drills and each indicated they have participated in fire drills and knew what to do. The youth indicated the frequency of drills as once a month, three to four times a month, and every two weeks. One youth could not recall how often they do drills. Another youth was not sure how often; however, recalled there were a lot of drills. Five staff interviews were conducted, and each reported they had recently participated in a fire drill.

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

The program has a policy and procedures addressing Disaster and Continuity of Operations Planning (COOP). The program provided documentation the COOP was reviewed April 10, 2019. The program sent the plan to the Department which was confirmed by email April 11, 2019. The Department's regional residential director signed the plan April 15, 2019. The program had assembled all equipment and supplies for emergency evacuation, as required. The plan addressed all required elements. The program created and maintained a hard-copy binder with all required information on each youth in the program in the event of an emergency. Staff interviews, including with the facility administrator, indicated the program maintains one copy of the COOP in master control and the facility administrator's office, which was observed by the review team.

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

The program has a policy and procedures addressing storage and inventory of flammable, poisonous, caustic, and toxic items and materials. Informal staff interviews indicated chemicals were stored only for immediate use in the laundry room. The inventory of chemicals was maintained in the daily housekeeping log, as required. The inventory log and on-hand chemicals were reviewed during annual compliance review and found to be accurate. An observation of chemical storage revealed the program had a spray bottle for a cleaning agent which was not

labeled. The program labeled the spray bottle when notified of the finding. The program reported they maintain their Safety Data Sheet (SDS) binder in Master Control (centralized location) so all staff can access them in the event they are needed instead of with the chemicals. The program created a second binder containing all SDS sheets and placed it in the chemical closet during the annual compliance review.

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

The program has a policy and procedures addressing youth handling of flammable, poisonous, caustic, and toxic items and materials. Policy and procedures state youth are not allowed to use flammable, poisonous, and toxic items and materials. Five youth were interviewed regarding use of certain chemicals; three youth indicated they have used paint, one indicated floor wax, two used laundry soap, and two indicated they do not use any chemicals/cleaning products. The youth clarified staff spray cleaning liquid on the surfaces and youth wipe them down. Follow-up interviews indicated staff pour laundry soap crystals into a cup and youth pour it into the washing machine and staff poured out paint into containers, so youth could paint walls with a brush. Youth were under staff supervision at all times. The staff reported the use of these chemicals under staff control and supervision was used to teach youth independent living skills. In addition, the paint utilized by the program was reported as non-toxic.

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

The program has a policy and procedures addressing disposal of flammable, poisonous, and toxic items and materials. The program reported there have been no instances in which the program disposed of chemicals since the last annual compliance review; however, the program process is to utilize the county hazardous waste site. An interview with the facility administrator confirmed chemicals are disposed at the local county dump in the event disposal is required. In addition, the program does not have a kitchen to require the disposal of cooking materials.

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

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has a policy and procedures addressing visitation and communication. The program allows youth to write to and receive mail from approved family members and have weekly telephone calls to the same individuals. Visitation is scheduled on Sunday afternoons. The clinical care management (CCM) team keeps a visitation log, a telephone log, and a correspondence (mail) log. Telephone communication with family is also documented in each youth's case management record. CCM staff review all outgoing and incoming mail and log it into the correspondence log. Alternative visitation is arranged when requested. All five reviewed records documented weekly youth calls to family members. The program had family day twice during the annual compliance review period. The program utilized two forms for family day and regular visitation: Visitation Documentation Summary and Visitation Sign-in/out Log. All youth were frisk and full-body visual searched using the appropriate form following visitation. During the annual compliance review, the clinical care manager (CCM) received youth mail. The CCM

logged the mail on the youth's correspondence sheet but did not deliver the mail to the youth. The CCM scheduled a time on Thursday to deliver mail to the youth. The annual compliance review team observed the process of the CCM delivering mail to the youth. During the process, the CCM opened the mail and scanned the contents. The mail contained a letter from the mother of the youth. It also contained a letter from someone who was not on the approved correspondence list. The CCM informed the youth he would not be allowed to have the letter from the unauthorized person and it would be returned to the mother with an explanation. The mother's letter was given to the youth. Five youth were interviewed and each indicated they were allowed to communicate with family by mail and phone.

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

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

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

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

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

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

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

The program has a policy and procedures addressing safety planning process for youth. The safety plans created for the youth committed to the program contained all required elements. Five youth were reviewed and three were applicable for safety planning upon admission, the other two youth were admitted prior to the safety planning process being put in place. Two additional applicable youth records were provided for review. Four of the five reviewed youth records documented youth received the safety plan within the required fourteen days. One youth received his safety plan sixteen days after admission, two days late. Four safety plans were applicable for a thirty-day review. There was no documentation in the binder each of the four youth's safety plans were reviewed within the time frame. The program did not have a process in place to complete the thirty-day review. Five staff were interviewed regarding youth safety plans. Two of the five staff reported they did not know anything about the safety plan or

where they were located. Two staff knew the book was in master control; however, they could not explain the process. One staff indicated each staff has access to the safety plan book but could not explain the process. An interview with the facility administrator revealed safety plan binders are maintained in the youth's mental health record with additional copies maintained in a binder in Master Control for staff to reference. In addition, safety planning has been addressed with staff during the July and August 2019 General All-Staff Meetings. Five youth were interviewed regarding their safety plans. Three of the five youth indicated they participated in the development of their safety plan and two youth did not remember specifically participating in the development of the safety plan.