STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

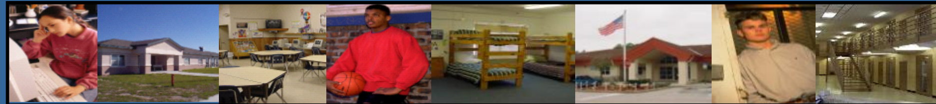
BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Bartow Youth Academy
True Core Behavioral Solutions, LLC

(Contract Provider)
2415 Bob Phillips Road
Bartow, Florida 33830

Review Date(s): July 14-17, 2020



Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

Rating	Definition
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:

Brenda Comadore, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Marvin Bliss, Office of Accountability and Program Support, Regional Monitor (Standard 4)
Kara Brown, Office of Accountability and Program Support, Regional Monitor (Standard 1)
Cedric Cliatt, Executive Director of Melbourne Center for Personal Growth - AMIkids Space Coast (Standard 2)
Paul Czigan, Office of Accountability and Program Support, Regional Monitor (Interviews)
Gregory Mahoum-Nassar, Office of Accountability and Program Support, Regional Monitor (Standard 5)
Stephanie Shay, Office of Accountability and Program Support, Deputy Regional Supervisor (Standard 3)

Program Name: Bartow Youth Academy
Provider Name: True Core Behavioral Solutions, LLC
Location: Polk County / Circuit 10
Review Date(s): July 14-17, 2020

MQI Program Code: 1268
Contract Number: R2118
Number of Beds: 28
Lead Reviewer Code: 172

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.10 Delinquency Intervention and Facilitator Training	
2.05 Gang Identification: Notification of Law Enforcement	
2.06 Gang Identification: Prevention and Intervention Activities	

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 *	Non-Applicable
1.05	Incident Reporting (CCC) *	Satisfactory
1.06	Protective Action Response (PAR) and Physical Intervention Rate	Non-Applicable
1.07	Pre-Service/Certification Requirements *	Satisfactory
1.08	In-Service Training	Satisfactory
1.09	Grievance Process	Satisfactory
1.10	Delinquency Intervention and Facilitator Training	Limited
1.11	Life Skills Training Provided to Youth	Satisfactory
1.12	Restorative Justice Awareness for Youth	Satisfactory
1.13	Gender-Specific Programming	Satisfactory
1.14	Internal Alerts System and Alerts (JJIS)*	Satisfactory
1.15	Youth Records (Healthcare and Management)	Satisfactory
1.16	Youth Input	Satisfactory
1.17	Advisory Board	Satisfactory
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory
1.20	Recreation and Leisure Activities	Satisfactory

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Youth Supervision *	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	Ten Minute Checks *	Satisfactory
5.05	Census, Counts, and Tracking	Satisfactory
5.06	Logbook Entries and Shift Report Review	Satisfactory
5.07	Key Control*	Satisfactory
5.08	Contraband Procedure	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	Vehicals and Maintenance	Satisfactory
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Satisfactory
5.13	Tool Inventory and Mangement	Satisfactory
5.14	Youth Tool Handling and Supervision	Satisfactory
5.15	Outside Contractors	Satisfactory
5.16	Fire, Safety, and Evacuation Drills	Satisfactory
5.17	Disaster and Continuity of Operations Planning (COOP)	Satisfactory
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	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

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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 TrueCore Behavioral Solutions, LLC, through a contract with the Department. The program provides services for a youth population diagnosed as Borderline Intellectual Functioning. Youth receive medical and psychiatric services, behavior management, and psychological services from a licensed psychologist if needed, certified behavioral analysis if needed, on-site education, vocational education, and specialized life skills training. Clothing is also provided by the program. In addition, the program fosters 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 clinician authority who is a licensed social worker, two licensed clinicians, two 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 serves 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 a multi-purpose room. The program has twenty-seven security cameras providing coverage, each of which were operational at the time of the annual compliance review. At the time of the annual compliance review, the program had one vacant position; youth care worker I.

Strengths and Innovative Approaches

- Youth are also given a choice regarding speakers who have been brought into the program. Youth feedback is obtained through student advisory board meetings, daily meetings held with all youth in the dorms and informal interactions.
- Youth are provided the opportunity to participate in monthly outings. This is viewed as a privilege which many youth work towards. They are exposed to community events as well as social settings where they practice newly acquired or polished social skills, and later receive informal feedback from the staff members accompanying the youth.
- Treatment is modified at Bartow Youth Academy to accommodate the borderline developmentally delayed (BDD) functioning level of the youth. The youth are provided with alternative behavior contracts or personalized behavior self-monitoring sheets to empower them to implement new skills or make behavioral changes to see success in the program. Youth are given tangible rewards and reinforcements through incentives such as Clinical Raffle, Mega Monday, Movie Nights, as well as unannounced or surprise rewards.

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 two new staff. Each of the two staff had clear and eligible background screenings in the Agency for Healthcare Administration (AHCA) Clearinghouse. In addition, both employee records had documentation the criminal history report, Staff Verification System module, the Department's Central Communications Center (CCC) personal involvement history, and the Florida Department of Law Enforcement (FDLE) Automated Training Management System (ATMS) were reviewed prior to hire. Neither of the two staff required an exemption prior to hire. Both background screenings were completed prior to hire. One of the new staff was applicable for pre-employment background screenings which was completed with a passing score as required. The remaining staff, the human resource coordinator was not required to complete the pre-employment assessment tool. The two new staff were added to the program's AHCA Clearinghouse roster. The program submitted their Annual Affidavit of Compliance with Level 2 Screenings Standards to the Department's Background Screening Unit (BSU) on December 6, 2019. The Polk County School Board which provides teachers for the program, submitted their Annual Affidavit of Compliance with Level 2 Screening Standards to the BSU on December 6, 2019.

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 four applicable staff for rescreenings. Three of the four were submitted and completed, as required. One staff's due date for rescreen was September 9, 2020; leaving two months remaining before the required submission.

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 trauma responsive practices.*
- *The program shall complete or schedule a TRACE self-assessment.*

The program maintains a policy and procedures to ensure they provide an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. The program's policy states the program has a zero-tolerance policy regarding any abuse. The policy states all staff must immediately report any knowledge or suspicion regarding an incident of abuse or sexual harassment which may have occurred in the program. Staff must contact the Florida Abuse Hotline if the youth is under the age of eighteen or the Department's Central Communications Center (CCC) if the youth is eighteen years of age or older. If a youth refuses to make an abuse call, staff must make the call. Staff are to verbally notify the on-duty supervisor once a call has been completed and let the supervisor know why the call was made. This is not required if an anonymous call was made regarding sexual misconduct. Staff must also complete an internal incident form and forward the form to their supervisor once a call has been made. The assistant facility administrator then completes the appropriate notification to the CCC and regional director. All notifications are documented on the program's internal incident form.

In an interview with the facility administrator, it was confirmed all staff have access to report abuse to the Florida Abuse Hotline and the CCC. All staff are provided pre-service and annual training on abuse reporting. Five staff interviews were conducted and four stated they notify their supervisor if a youth requests a call. Another staff and one of the four interviewed staff also reported they allow youth to make the call. All interviewed staff reported they have never observed a staff member refuse a youth a call to the Florida Abuse Hotline or observed a staff member using profanity, threats, intimidation, or humiliation when interacting with youth. Five youth were interviewed and each stated they have never been stopped from calling the Florida Abuse Hotline or the CCC. Each youth feels staff is respectful when talking with them or other youth. A review of the five youth interviews indicated each youth feels safe at the program. All youth, staff, visitors, interns, and volunteers are to have unimpeded access to the Florida Abuse

Hotline without interference or retaliation of any kind. During a program tour, the Florida Abuse Hotline telephone number and the CCC telephone number for youth eighteen years of age and older were observed to be posted throughout the program.

Staff adhere to a code of conduct which is indicated by each staff's signature on the employee handbook. An interview with the facility administrator (FA) indicated the staff code of conduct includes all types of abuse, neglect, profanity, contraband, and other items. There are several layers of disciplinary action if these actions occur.

There was a total of three abuse hotline or CCC incidents since the last annual compliance review. A review of all the incidents found they were all CCC incidents. One incident was a youth behavioral incident, one was a staff complaint, and the remaining incident was information only. None of the incidents included a potential human trafficking victim, commercial sexual exploitation, or labor trafficking. The environment is free of physical, psychological, and emotional abuse. There were no incidents related to physical, psychological, or emotional abuse since the last annual compliance review. The program completed a Trauma Responsive and Caring Environment (TRACE) self-assessment to assist in incorporating trauma responsive principles into the program environment. According to the FA, the TRACE self-assessment was completed in April 2020. The program provided a copy of the TRACE self assessment during the annual compliance review.

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

The program had no incidents of physical, psychological, or emotional abuse in the facility during this review period; therefore, this indicator rates as non-applicable.

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 maintains a policy and procedures to ensure the Department's Central Communications Center (CCC) is notified within two hours of an incident occurring or within two hours of any program staff becoming aware of a reportable incident. There were three reportable incidents which took place within the last six months. One of the incidents was due to youth behavior, one was a complaint against staff, and one was miscellaneous information. Each incident was reported within the required two-hour time frame. One of the three incidents was applicable for documentation in the logbook and was documented in the logbook. The remaining two incidents were not applicable because one contained confidential staff information and the other was to the COVID-19 pandemic. A review of incidents, grievances, and youth records found there were no additional incidents which should have been reported to the CCC. The facility administrator (FA) was interviewed and reported all staff receive pre-service and in-service training on abuse reporting and CCC reporting. The FA also stated during every all staff meetings, the program reviews important incidents at morning management

meetings. The management team reviews all program incidents and abuse reporting is addressed with each youth during orientation.

1.06 Protective Action Response (PAR) and Physical Intervention Rate	Non-Applicable
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.	

There have been no Protective Action Response (PAR) incidents during this review period; therefore, this indicator rates as non-applicable.

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. Four of the five pre-service training records were applicable. Each of the four 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 and required Department and contract trainings. The remaining staff was hired on February 17, 2020 and serves as the human resource coordinator position with no youth contact and is located on another TrueCore campus. All trainings were documented in the Department's Learning Management System (SkillPro) within thirty days of completion. Each of the four applicable 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 Office of Staff Development and Training on February 7, 2020 and approved on February 17, 2020.

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 more than the required 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) within thirty days of completion. Documentation supported all facilitators of first aid, CPR, AED, and PAR trainings were certified to deliver the trainings. A

review of the staff roster confirmed 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 approved in-service training plan which was submitted to the Department's Office of Staff Development and Training on February 7, 2020. Additionally, 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 maintains a policy and procedures which include the training requirements for the grievance process. All program staff are trained on the grievance process, facility operating procedure for grievances, and required documentation during their pre-service training. Five interviewed staff indicated they were knowledgeable of the program's grievance process. The program's grievance process includes an informal phase, which is completed by utilizing Speak-Out forms, a formal phase, and an appeal phase. The steps and time frames are documented for all phases. An interview with the facility administrator confirmed the grievance process. A review of the program's grievances found the program maintains copies of grievances for the past twelve months. The program had three grievances filed during the review period. The nature of the grievances were mental health services, safety, food, clothing, and staff. The informal phase was not completed for any; however, it is not required. Each grievance was resolved prior to the appeal phase and responded to youth within the proper time frame. Five youth were interviewed and three stated grievance forms are placed throughout the facility. Four youth stated they have never filed a grievance, while one youth stated having used the grievance form. Four of the five youth indicated they were aware of the grievance process and all five youth stated they can request assistance in completing a grievance form.

1.10 Interventions and Facilitator Training	Limited 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 interventions to each youth including Life Skills Training (LST), Boy's Council, Life Centered Education (LCE), Skillstreaming the Adolescent, Young Men's Work (YMW), and Living in Balance. LST is an evidence-based practice. Additional groups held include Thought Changing Cards, Art/Play therapy, Anger Management, and Restorative Justice. Four staff members facilitated groups during the annual compliance review period, all of which were master's-level clinicians or licensed therapists. A review of staff training records indicated each staff has the required training, education, and experience to deliver delinquency intervention services which were considered when assigning staff to deliver the interventions.

An interview with the facility administrator (FA), who is the acting clinical director, confirmed the program is providing the contractual intervention services and staff are appropriately trained to administer groups. Additionally, the FA stated, delinquency intervention is interwoven into the level system where the youth learn to gain skills on the impact of their behavior on the community, the victim, how to give back to the community through pro-social methods, improve cognitive reasoning, and youth empowerment. All five interviewed youth stated they are participating in intervention groups.

A review of group sign in sheets confirmed the program completes all groups on the contract table except for LCE ,LST and Boy's Council. The program does not have a current session of Boy's Council due to not having enough youth to participate. The program has been limiting their number of intakes due to the COVID-19 pandemic. The program's contract indicates LST and Boy's Council are to be held twice a week; however, a review of group sign in sheets indicated when in session, they are held one time per week. LCE is to be held one time per week; however, no sessions were held the weeks of March 15, 2020, April 11, 2020, May 9, 2020, or June 6, 2020. 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. The program holds groups for scheduled times; however, the day each group is held may vary because of staffing or scheduling changes.

A review of five youth records found each youth was participating in delinquency interventions which are evidence-based, promising practices, or practices with demonstrated effectiveness. Each youth was participating in a delinquency intervention addressing a priority need as identified by the Residential Assessment for Youth (RAY). Each youth's performance plan also addressed an identified priority need.

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 maintains a policy and procedures which ensure interventions or instruction focusing on developing life and social skill competencies in youth, are provided. Masters-level clinicians or licensed therapists facilitate Life Skills Training (LST), Life Centered Education (LCE), Skillstreaming the Adolescent, Boy's Council, Young Men's Work, and Living in Balance. The program also provides Anger Management, Thought Changing Cards, Goals Group, and Art/Play therapy. A review of the program's activity schedule and group sign in sheets indicated groups are held seven days a week. The designated mental health clinical authority (DMHCA) reported life skills groups are geared towards the borderline developmentally disabled (BDD) population at the program to meet their needs and abilities. A review of the curriculum and group sign in sheets verified the youth receive life and social skills intervention services specifically addressing communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking, including problem solving and decision making.

Five youth interviews were conducted and each reported they participate in groups. Each youth was able to describe skills they learned in groups and explain how they have practiced these skills. An interview with the facility administrator (FA), who is also the acting clinical director, confirmed the program is providing the contractual intervention or instruction to youth. Additionally, the FA stated as the clinical director, monthly fidelity checks are conducted to

ensure all mental health services delivered to youth include individual, family, and group sessions and weekly clinical supervision is held with each therapist to aide in providing adequate services to youth.

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. 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 and acting clinical director, revealed the youth participate once a month in Victim Impact: Listen and Learn, restorative awareness group. The FA additionally stated the youth have not been able to participate in community restorative activities or host guest speakers, due to the COVID-19 pandemic; however, prior to COVID-19 pandemic, youth participated in a local triathlon to help set up, tear down, give water to participants, and clean up as a restorative community activity. A review of five youth mental health records found each youth received services in restorative justice. The restorative justice group is held on the first weekend every month; 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 restorative justice 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 requires two 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 teenaged boys diagnosed as borderline developmentally disabled (BDD). A review of the program's groups schedule confirmed both Young Men's Work and Boy's Council were offered, as required, by the program's contract. The delivery of these groups was confirmed through the facility administrator (FA) and designated mental health clinical authority (DMHCA) interviews. Group sign-in sheets and the group curriculum 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 participated in the gender- specific

groups. According to the FA, the program provides The Boys Council and Young Men's Work to address the needs of the targeted gender-specific group.

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 which outlines how alerts are identified, documented, updated, and communicated to staff. The program uses an alert board in master control, which is inaccessible to youth and a medical alert log to document internal alerts. A review and comparison of the Department's Juvenile Justice Information System (JJIS) alerts and the program's internal alerts confirmed both alert lists were consistent. 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 on each youth. A 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 on four of the five youth. The remaining youth had an internal gang alert which was not reflected in JJIS. The program immediately updated the alert to reflect the status as a gang alert in JJIS. All other alerts were opened and closed appropriately within proper time frames. A review of youth records in case management, mental health, and medical services did not reveal any issues with alerts. Five staff interviews were conducted and each 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 and psychiatric meetings with clinical team.

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 records for each youth, an individual healthcare record and an individual management record. Five youth individual management records were reviewed and each contained the youth's name, Department of Juvenile Justice Identification (DJJID) number, date of birth, county of residence, and committing offense. Each record contained a table of contents with sections labeled legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous. All youth

records are labeled “Confidential” and are maintained in the locked clinical office or medical office, inaccessible to the youth.

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

The program has a formal process to promote constructive input by youth including the youth advisory board, Speak-Out forms, youth surveys, and daily meetings. This process was confirmed in an interview with the facility administrator. A review of monthly advisory board meeting minutes and Speak-Out forms confirmed youth are given opportunities to provide input. Five youth interviews were conducted and each youth stated they are given opportunities to provide input. Three youth stated they can use Speak-Out forms or provide written input, two youth stated they have a youth council, and two youth stated they can talk with leadership.

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 (CAB) which is scheduled to meet on a quarterly basis and is combined with another program in the community. A review of the CAB binder found the last quarterly advisory board meeting was held on December 27, 2019. The sign in sheet and agenda were reviewed. Quarterly meetings were scheduled for March and June of 2020; however, a letter was sent out to board members canceling the meetings due to the COVID-19 pandemic. During the annual compliance review, a CAB meeting was scheduled for August 30, 2020 at 1:00 p.m., to be held on ZOOM video conferencing. A letter sent to the advisory board members was reviewed confirming the board members’ invitation to the upcoming meeting. A review of meeting sign in sheets, the board roster, and letters from the program found the facility administrator (FA) solicited involvement from a law enforcement representative, judiciary community representative, other community partners, business community representative, school board or district representative, faith community representative, Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex (LGBTQI) community representative, victim, victim advocate, or other victim services community representative, and a parent/guardian whose child was previously involved in the juvenile justice system.

Reviewed documentation confirmed a representative from each category was a member of the advisory board or were invited to join the advisory board. An interview was conducted with the FA who stated they have reached out to Lakeland Youth Alliance, a LGBTQI agency, as well as a parent/guardian of a youth who was previously in the program. The FA stated the advisory board provides education and vocational services, Christmas gifts and meals, and community service outreach. An interview was also conducted with a board member from the Polk County Board of Education. During the interview, the board member stated they served on the board for approximately seven years and attended fifteen or more advisory board meetings. The board member stated advisory board meetings are typically held quarterl, and the board has accomplished such tasks as planned youth outings, scheduled guest speakers, and repaired program fencing and wiring.

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 to determine the system of staff communication and opportunities for youth, staff, and families to provide input and feedback into the program. The results and recommendations of the youth and family surveys are conducted at the beginning, during, and after youth stays. The Monitoring and Quality Improvement Report and the Department's Comprehensive Accountability Report were found to be discussed during monthly staff meetings and integrated into programming. An interview with the facility administrator (FA) confirmed in addition to the surveys and reports; gender, race, and recidivism are discussed with staff at the monthly all-staff meetings, daily morning management meetings, weekly clinical supervisions, and shift briefings. The FA also discussed efforts to maintain appropriate staffing and to improve staff morale which included themed employee appreciation days, awarding of employee of the month and year, the TrueCore Way initiative, football Fridays, lunch at the all-star meetings, staff raffles, One Dollar Jeans Day, Spirit Weeks, Above and Beyond Awards, and recruitment bonuses. 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 discussed are valuable and informative. Three of the five staff reported they are briefed on youth and parent/guardian survey results and annual reports; however, two staff reported they were not. Three staff reported communication is very good and two reported communication is good. Each of the five staff reported the FA has an open-door policy and staff are able to share any concerns or suggestions they have at staff meetings.

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 which ensures the requirements for evaluating staff performance are completed annually and after the first ninety-days of hire. A review of position descriptions confirmed job duties are clearly outlined for each staff position. A review of five pre-service staff records confirmed each staff received a ninety-day performance evaluation and a review of five in-service staff records confirmed each staff received an annual performance evaluation. All ten staff reviewed were evaluated and based on the 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 of employment and annually thereafter. Five staff were interviewed and two confirmed they received their ninety-day evaluations, one staff reported being evaluated every six months, and two stated they received monthly coaching notes from their supervisors. All five staff stated they are given monthly coaching notes from their supervisors.

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 for the provision of recreation and leisure activities based on the developmental levels and needs of the of youth at the program. A review of the program's activity schedule documented youth are allowed to participate in a variety of leisure activities, as well as indoor and outdoor recreation for at least one hour each day. During recreation time, the youth participates in the designated activity on the recreation calendar or an alternative indoor workout, if weather does not permit outside time. Youth are given a choice of leisure activities in the evenings and on weekends. Youth are encouraged to explore interests during recreation and leisure time. Youth are also given opportunities to provide input into desired activities through the youth advisory board and Speak Out forms. Recreation is documented in the logbook through movement when youth are outside. An observation of indoor recreation was made to verify staff take precautionary measures to ensure safe distancing of youth to prevent the spread of COVID-19.

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 reviewed detailing daily activities. An incentive schedule created by the recreation therapist, is posted throughout the program to inspire youth to work towards participating in additional daily activities as incentives for good behavior. The recreation therapist also created workouts for youth when weather does not permit outside activities. 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.

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 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 within five working days notifying each 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 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 stated the orientation to the program included program rules, procedures, schedules, and was completed within twenty-four hours of arrival. Additionally, each of the youth were able to explain the orientation process.

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

The program has a policy and procedures 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. 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. A review of five youth case management records revealed one was applicable for consent for youth eighteen years or older. The program provided three additional applicable records which were reviewed for a total of four. Three of the four reviewed records contained written consent of youth eighteen years or older. The remaining one youth record did not have documentation of a written consent of youth eighteen years or older.

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 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 program has an internal alerts board in master control which identified each youth's classified risks and is always accessible to staff. 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. None of the five youth were classified as being at risk for suicide or an escape risk. One youth were classified as being a medical risk and another youth was classified as being a gang member. None of the five youth were classified as being a security risk. An interview with the facility administrator (FA) confirmed newer youth are moved towards the front of the dorms (rooms one through four). The FA stated the program reviews mental health issues, age, size, and maturity when deciding which rooms youth are placed in. In addition, youth with specific diagnoses are placed on the smaller dorm to limit noise and social interactions. A review of five youth case management records confirmed each youth received a new risk assessment at their monthly formal treatment team meetings. All risk assessments were completed correctly with no issues.

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

The program has a policy and procedures 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 one additional applicable youth record for review of gang identification and notification. One of the two 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. The remaining applicable record did not contain documentation of local law enforcement notification in writing of youth's gang affiliation nor the gang alert in the Department's Juvenile Justice Information System (JJIS) upon initial review of the record. The program updated the record to include notification to local law enforcement, in writing, the youth's educational counselor, juvenile probation officer (JPO), and post-residential counselor of youth's gang affiliation; and the gang alert in JJIS, prior to the end of annual review period. However, notification to law enforcement was completed six months after the youth was identified with gang affiliation.

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

The program has a policy and procedures outlining the program's process for gang prevention and intervention. A review of the group sign-in sheets confirmed the program conducted monthly gang prevention and intervention groups the entire annual compliance review period. Gang prevention and intervention efforts provided to the youth included Identifying Triggers, Missing Family, and Destiny Determined by Choices. Five youth records were reviewed and one youth was applicable. The program provided an additional applicable youth record. One of the two applicable reviewed records found the youth participated in monthly gang prevention and intervention groups. The remaining youth record did not have documentation the youth participated in gang prevention and intervention groups from the date of the youth's admission on February 20, 2020 until the annual compliance review. Both of the youth's performance plans had a gang goal indicating the youth 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 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 the RAY reassessments will be completed on each youth every ninety days. Two of the five youth records reviewed were applicable and had documentation reassessments were completed within ninety days after the completion of the

initial RAY assessment and was maintained in the youth's official record. The remaining three youth were not applicable as they were not in the program ninety days to receive a RAY reassessment.

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 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 confirmed all five records contained a completed YNAS within thirty days of 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 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. 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). All performance plans contained target dates for goal completion. All five performance plans addressed each youth's top three criminogenic needs and contained specific delinquency interventions with measurable outcomes. 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. 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. Four of the five youth records had performance plans developed within thirty days of admission. The remaining performance plan was developed within thirty-three days of admission; three days later than the required time frame. Five youth were interviewed and each indicated they participated in the development 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 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 none were applicable for performance plan revisions. The program provided one additional record for review of performance plan revisions. The one applicable record contained performance plan revisions based on newly acquired or revealed information and on the youth's RAY reassessments and 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 which addresses the completion of performance summaries and their transmittal. A review of five youth case management records revealed two were applicable for ninety-day performance summaries. Both records contained a performance summary completed ninety days after the completion of the original performance plan. Both reviewed records contained performance summaries prior to the youth's release, discharge, or transfer from the program. Both 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. Both records contained information regarding the youth's level of motivation and readiness to change. Both applicable records contained documentation confirming 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. Both performance summaries were signed and dated by the treatment team lead, staff member preparing the summary, facility administrator, and the youth. Both 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) which was completed forty-five days prior to the youth's release. The third record contained a PRN which was completed thirty-seven days prior to the youth's release. 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 reviewed three closed records were for youth who were considered sexually violent predators and did not require additional discharge documentation or notifications. All three records confirmed the required victim notification was completed prior to the youth's release from the program. All three records indicated the juvenile probation officer (JPO) was provided copies of the performance summaries, transition plans, and psychological/psychiatric reports upon completion. Interviews with five youth indicated all five youth received a copy of their performance summaries.

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. During admission, the program mails each parent/guardian an admission letter explaining the case management process and encouraging parent/guardian participation in an online survey, the performance plan, and treatment plan process. Attached to the admission letter is a copy of the program's parent handbook which details 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 confirmed each youth had regular telephone contact with their parent/guardian. All five records contained documentation parent/guardians were invited to participate in the youth's performance planning and treatment meetings. An interview with the facility administrator (FA) indicated the program encourages parental involvement during the admission calls with medical and case managers; parental assessment mail-outs; Parenting with Love and Limits; Family Day, family sessions, and visitations. Interviews with five youth also indicated parent/guardian are contacted by the case managers to gain their participation in case management services.

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 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. Five records were reviewed. 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.

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

The program has a policy and procedures for the 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 incorporating the mental health and substance abuse plan into the performance plan.

2.15 Treatment Team Meetings (Formal and Informal Reviews)	Satisfactory Compliance
A residential commitment program shall ensure the intervention and treatment team meets every thirty days to review each youth's performance, to include 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 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 participation from the youth's juvenile probation officer (JPO) and other pertinent members of the treatment team through advance written notification. All five records reflected the youth's parent/guardians received an advanced notice of all treatment team meetings. All five reviewed records also contained documentation confirming the clinical case manager and youth participated in bi-weekly informal reviews of the youth's performance plan and 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. All five records reflected formal performance reviews were completed every thirty days and 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. An interview with five youth indicated each are provided an opportunity during their treatment team meetings to demonstrate skills they have learned in the program and stated whether staff review their performance to include progress on performance plan goals, positive and negative behavior, and treatment progress.

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

The program 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, resumé, and documentation of an appointment with Career Source Center. Two of the three records contained evidence of a sample resumé and appropriate documents to obtain employment. The remaining one youth record had evidence of a sample resumé but did not have documents essential to obtaining employment. All three youth records had documentation of notification to the parent/guardian being made aware of vocation plan. The program does not have a contracted minimum length of stay of nine months; therefore, the Career and Professional Education (CAPE) component is not applicable.

An interview with the facility administrator and lead teacher confirmed, Life Skills groups, resumé writing, Daniel Memorial assessment, Career Shines, vocational training, and career research are the vocational services provided to youth at the program.

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 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, video observation, and interviews with education staff confirmed education is taking place as scheduled. Five youth interviews were conducted and each youth confirmed minimal interference in education. According to the lead teacher, the instructional schedule is adhered to and is 7:30 a.m. to 2:10 p.m. with lunch from 11:15 a.m. to 12:20 p.m.

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

The program has a policy and procedures regarding educational transition planning. Applicable staff and youth at the program complete an education transition plan prior to youth release including provisions for continuation of education and/or employment. Three closed youth case management records were reviewed. Two of the three youth case management records contained documentation of an individual education transition plan developed on the youth's post release goals attended by the youth, parent/guardian, education representative, post release staff, and school district. The remaining youth record did not have documentation the development of the individual education transition plan was attended by the school district representative. All three records contained documentation of services and interventions based on the student's assessed educational needs and post-release education plans.

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 addressing transition planning, conferences, and Community Re-Entry Team (CRT) meetings. Three closed youth records were reviewed for compliance with transition planning and CRT meetings. All 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. All three records had transition plans conducted with an invitation letter sent to the juvenile probation officer (JPO) and parent/guardian. Two of the three records had confirmation the JPO was sent the transition plan with a request for signature. The remaining youth record had no documentation the JPO was sent the transition plan with a request for signature. All three reviewed records confirmed completion of a CRT meeting prior to the youth's release. All three reviewed records had documentation the youth participated in a CRT meeting.

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 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 for each of the three records. 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. Two of the 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, resumé, and completed sample job applications. The remaining exit portfolio did not have the original birth certificate, due to the COVID-19 pandemic shut down of local offices; however, the exit portfolio did have a letter documenting the request for the birth certificate, vocation certificates the youth earned in the program, educational documentation, school transcripts, resumé, and completed sample job applications.

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.

2.22 Safety Planning Process for Youth	Satisfactory 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 records were reviewed and all five youth had safety plans within the fourteen days of arrival to the program. Five youth reported they participated in their safety plan's development. Three of the five safety plan updates were completed within the required time frame and indicated parent involvement in planning. The remaining two youth safety plan updates were late by four days and two initial plans did not have documentation indicating parent/guardian involvement with the development of safety plans; however, the parent/guardian surveys of the youth indicated parent involvement in the planning was solicitated. Four of the five safety plans had documentation incorporating recommendations from the previous or current clinical assessment or screening instrument. The remaining safety plan did not reflect documentation any recommendations were incorporated from previous or current clinical assessments or screening instruments. Five staff interviews were conducted and each staff stated the safety plans were stored in master control and are reviewed during treatment team and when there is a new youth safety plan.

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. The 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's license found it to be current and active with an expiration date of March 31, 2021. An interview with the DMHCA stated the position is responsible for overseeing clinical services to ensure youth are receiving services according to the contractual requirements. No services were missed. The position is also responsible for ensuring the timely and accurate completion of the required assessments, evaluations, and treatment plans. The regional clinical director who is a licensed mental health counselor, and the regional assistant clinical director provide coverage for the program, in the absence of the DMHCA. A review of their licenses confirmed both licenses are current and active with an expiration date of 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 a policy and procedures addressing licensed mental health and substance abuse clinical staff. The program currently has three full-time licensed mental health counselors (LMHCs). All three LMHCs have a clear and active license which expire on March 31, 2021. One of the LMHCs serves as the designated mental health clinician authority (DMHCA) for the program. The program has a Chapter 397 license with the program's physical address included on the license, which allows the program to provide substance abuse clinical services. The Chapter 397 license does not expire until April 7, 2021. Current clinical staffing is in accordance with the program's contract.

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 two licensed clinicians and two non-licensed clinicians who provide both case management and clinical services to youth in the program. Schedules are rotated to ensure the program has clinical staff on-site seven days a week. Both non-licensed mental health clinicians hold a master's-level degree in a relevant field of study. Documentation was reviewed, confirming twenty hours of on-the-job-training (OJT) in assessing suicide risk, mental health crisis intervention, and emergency mental health services for each of the non-licensed clinicians. Additional documentation was reviewed which confirmed the OJT included the administration of five assessments of suicide risk or crisis assessments were conducted in the physical presence of a licensed mental health professional, which was documented on Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk form. A review of supervision logs confirmed both non-licensed mental health clinical staff received at least one hour on-site face-to-face direct supervision by the designated mental health clinician authority (DMHCA) each week.

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 addressing mental health and substance abuse admission screening. The screening process includes the administration of the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2) including all required content to screen every youth upon admission. A review of five youth records found all assessments were completed by a trained clinician in their entirety and entered in the Department's Juvenile Justice Information System (JJIS) on the day of admission. Reviewed documentation confirmed available information was reviewed to help staff get a clear picture of the youth's history. This review is documented on the admission classification form. Each reviewed MAYSI-2 Assessment indicated further assessment was required. All five youth were referred for and received a new Comprehensive Mental Health/Substance Abuse Bio-Psychosocial Evaluation and an Assessment of Suicide Risk (ASR), as each youth in the program is referred as part of the admission process. All five youth received an ASR within twenty-four hours of the MAYSI-2 being completed. An interview with the designated mental health clinician authority 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 addressing mental health and substance abuse comprehensive evaluations. The program's practice involves each youth receiving a new Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation within thirty days of admission. The comprehensive assessment includes elements for both mental health and substance abuse. During the admission process, clinicians also complete a Substance Abuse Subtle Screening Inventory (SASSI), a Social Skills Improvement System (SSIS), and a Trauma System Checklist for Children (TSCC) along with the recommendations from the initial psychiatric evaluation which aid in the completion of the Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation.

Each of the five reviewed records indicated new comprehensive evaluations were completed by a non-licensed clinical staff within thirty days of admission and all five were reviewed and signed by a licensed qualified professional within ten days, as required. The comprehensive evaluation includes demographic information, justification for the evaluation, reason for the assessment, behavioral observations, mental status examinations, methods of assessment, interviews, or other procedures used to acquire the needed information, patterns of alcohol and drug usage, impact on major life areas, risk of continued usage, discussion of findings, diagnostic impressions including the Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis, recommendations, and relevant background information. Relevant background information includes home environment, family functioning, history of abuse to include physical and sexual, history of neglect, witnessing of violence and other forms of trauma, behavioral functioning, physical health, and educational functioning. Results of the Comprehensive Mental Health/Substance Abuse Bio-Psychosocial Evaluation aid in the development of 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.*	

The program has a policy and procedures addressing mental health and substance abuse treatment. The program assigns each youth admitted to the program with a multidisciplinary treatment team. The treatment team consists of the youth and representatives from program administration, the residential living unit, medical staff, vocational training staff, education, mental health staff, substance abuse staff, other staff responsible for delinquency intervention and treatment services, and when possible the youth's parent/guardian. All five reviewed youth records validated the treatment teams for each youth were made up of the above-mentioned disciplines.

A review of five youth records for mental health and substance abuse treatment confirmed four of the five records contained a properly executed Authority for Evaluation and Treatment (AET) form. One youth is eighteen years of age; therefore, the record did not contain an AET. All five records contained a signed Substance Abuse Consent Form and Release form. Properly signed consents were completed for the youth eighteen years of age.

The program is licensed by the Department of Children and Families to provide outpatient substance abuse treatment services under Chapter 397 of the Florida Statutes. The Chapter 397 expires on April 7, 2021. Services are provided by qualified licensed and non-licensed clinical staff and include daily group therapy, weekly individual therapy, and monthly family therapy which are included in each youth's treatment plan. A review of five records documented mental health groups contained ten or fewer youth and substance abuse groups contained fifteen or fewer youth. Each of the five interviewed staff reported direct care staff do not facilitate mental health or substance abuse groups. All five interviewed youth reported participating in groups, individual, and family therapy. An interview with the designated mental health clinician authority confirmed the various treatment services provided and who facilitates the services.

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

The program has a policy and procedures addressing treatment and discharge planning. The process includes each youth receiving an initial treatment plan upon admission and an individualized treatment plan within thirty days of admission. A review of five youth mental health and substance abuse (MHSA) records found each record contained an initial MHSA treatment plan completed on the date of admission and included all the required elements. The documentation requirements include the youth's demographic information, reason for MHSA treatment, initial diagnostic impression or presenting symptoms, current Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis and symptoms, initial treatment methods, and initial treatment goals. All five MHSA initial treatment plans were signed by the clinician completing the plan and treatment team members who participated in creating the plan. All five of the plans were prepared by a non-licensed clinical staff and were countersigned by the designated mental health clinician authority (DMHCA) within ten days of completion. One of the five youth records found documentation for psychiatric needs to be included on the initial treatment plan. The remaining four youth did not have psychiatric needs identified on the initial treatment plans.

All five records contained an individualized treatment plan (ITP) completed within thirty days of the youth arriving at the program. Four of the five reviewed records confirmed the ITP included all Department required information while one record revealed an incorrect date of admission, an incorrect Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis code, and was missing one signature on the case manager's weekly progress notes. The errors were

brought to the program's attention, while the review team was on-site the program submitted a request to their electronic records department for correction of the date of admission, acknowledged the findings regarding the DSM code and noted they will correct subsequent clinical documents moving forward, as well as the signatures of the missing parties. The remaining four records confirmed the treatment was documented on forms which contained all the required elements. In all five records the ITP information included documentation of youth demographics, current DSM diagnosis and symptoms, mental health and/or substance abuse treatment goals, mental health and/or substance abuse treatment methods or interventions, psychiatric services, and strength and needs of both the youth and family. In four of the five records, the ITP was signed by the mental health/substance abuse clinical staff completing the plan and all other treatment team members who participated in the development of the plan. One ITP was missing the signature for the psychiatrist and the recreational therapist but did contain all other required signatures. All five reviewed records indicated the ITPs were completed by a non-licensed clinical staff and all five records were reviewed and signed by a licensed qualified professional within ten days of completion. In all five reviewed records, documentation was found indicating each youth is receiving the services prescribed in their ITP.

ITP reviews are completed every thirty days in order to document each youth's progress towards the goals and objectives on their ITP. All five treatment plan reviews contained the required elements such as documentation of a current DSM diagnosis and symptoms, mental health and/or substance abuse treatment goals with documentation of progress made by each youth in meeting each treatment goal, any changes in mental health and/or substance abuse treatment methods or interventions, psychiatric evaluations, and recommendations. In the five records reviewed, four were applicable for ITP reviews. At the time of the annual compliance review period, one record was not applicable for ITP reviews due to the youth's date of admission. There was a total of eleven treatment plan reviews. All eleven treatment plan reviews were completed within the thirty-day required time frame.

A total of three closed youth records were reviewed. All reviewed records contained documentation of the discharge instructions from the discharge summary discussed at the exit conference. All three youth discharge plan summaries were discussed with all required parties at the exit conference and a copy of the mental health/substance abuse treatment discharge summaries were provided to each youth, juvenile probation office, and the parent/guardian 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 has a policy and procedures addressing specialized treatment services. The program's contract requires the program to provide services for borderline developmentally disabled (BDD) youth. A review of five youth mental health records confirmed the program completed a new Comprehensive Mental Health/Substance Abuse Bio-Psychosocial Evaluation for each youth within thirty calendar days of admission, which serves as the developmental evaluation.

Upon admission to the program, each youth receives an initial treatment plan. Each youth receives an individualized treatment plan to address their developmental disability treatment needs no later than thirty-days after admission. All five youth progress notes reflected each

youth received daily developmental and psychosocial treatment through daily interventions and individual specific therapeutic activities. Reviewed progress notes documented group therapy is conducted seven days a week, individual counseling is conducted for each youth weekly, and family therapy is conducted at least monthly for each youth. 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 mental health counselor (LMHC) who acts as the designated mental health clinician authority (DMHCA). The DMHCA is 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. A review of group progress notes, program schedules, and youth interviews confirmed clinical staff are at the program seven days a week. Clinical care manager caseloads did not exceed the contractual limit of seven youth. In an interview with the facility administrator, it was stated all youth are diagnosed borderline intellectual functioning and participate in the specialized treatment services such as Social Skills Training, The Boys Council, and Skills Streaming.

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 maintains a policy and procedures addressing the provisions of psychiatric services. The provider contracts with a licensed psychiatrist to deliver services to each youth in the facility. The psychiatrist is licensed under Chapter 459, Florida Statutes and meets all requirements outlined within the Florida Administrative Code with a clear and active license expiring on January 31, 2022. A copy of the contract between the provider and the psychiatrist was available for review while on-site. The psychiatrist is available for on call and emergency consultation twenty-four hours a day, seven days a week. Only one youth from the original record selection was applicable; however, the program provided two additional youth records for review. A review of the three applicable youth records confirmed the psychiatrist provides input to the treatment team on the psychiatric status of each youth receiving psychiatric services; in addition; the psychiatrist's evaluation and recommendations for each youth is included in each youth's individualized mental health or substance abuse treatment plan.

The program does not have a psychiatric advanced practice registered nurse (APRN). A review of the program's psychiatric sign-in and sign-out logs confirmed documentation of the visits during the past six months, validating the psychiatrist was on-site every two weeks, as required with no lapse in services. A review of three records of youth prescribed psychotropic medication revealed each record contained documentation of youth's identifying data, diagnosis, target symptoms of each medication, evaluation and description of effect of prescribed medication on target symptoms, the name of the medication, dosage and quantity of medication with dosage ranges, frequency and route of administration, reasons for changes in medication and/or dosage, youth's adherence to the medication regime, height, weight, blood pressure, most recent serum drug levels or laboratory findings, telephone contact with the youth's parent/guardian to discuss the medication, signature and date of signature of the psychiatrist, and monthly documentation for Tardive Dyskinesia or other symptoms. Each youth on

prescribed psychotropic medication receives monitoring and review at a minimum of every thirty days. A review of three youth records revealed the psychiatrist actively participates in, manages, and supervises psychotropic medication services within the program.

Each of the initial diagnostic psychiatric interviews included a youth history, mental status examination, a Diagnostic and Statistical Manual of Mental Disorders (DSM–5) diagnosis, treatment recommendations, prescribed medications, explanation of the need for psychotropic medication, and frequency of medication monitoring. Each youth was seen within fourteen days of the referral. All three initial diagnostic interviews were documented on the Clinical Psychotropic Progress Note (CPPN) and clearly identified as an Initial Diagnostic Psychiatric Interview. All three records resulted in a prescription of psychotropic medication or a change to the youth's existing psychotropic medication. Page three of the CPPN was utilized to document the prescribing of or changes of prescriptions for the three youth. Documentation indicated all applicable youth on prescribed psychotropic medication were seen for medication monitoring by the psychiatrist every thirty-days. Upon review, two of the three records resulted in a prescription of psychotropic medication or a change to the youth's existing psychotropic medication. Due to the psychiatrist not being on-site during the annual compliance review period, an informal interview was unable to be completed.

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 in place detailing the program's suicide prevention procedures. The plan outlines how the program will safely assess and protect youth with elevated risk of suicide. The prevention of suicide plan received an annual review by the executive director and the designated mental health clinician authority on June 22, 2020. The plan included procedures for identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and the review process.

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

The program maintains a policy and procedures regarding the provisions of suicide prevention services which address the methods utilized for supervising, observing, monitoring, and housing youth identified through screenings, available information, or staff observations as having suicide risk factors. A review of five youth records found documentation each youth received a referral for an Assessment of Suicide Risk (ASR) upon admission. Each youth remained on

standard supervision based on the results of the ASR. The program was able to provide one additional applicable record of a youth placed on precautionary observation (PO) since the last annual compliance review. The reviewed record indicated the youth was placed on precautionary observation (PO) and placed under staff supervision until completion of the ASR. The ASR was completed within twenty-four hours using the Department's ASR form. The youth on PO was screened and subsequently maintained on PO. Supervision was maintained in the Suicide Precautions Observation Log. The precautionary placement was authorized by the designated mental health clinician authority (DMHCA), mental health staff provided supportive services, and a conference between the licensed mental health professional and DHMCA was documented to reduce the level of supervision. When the youth's follow-up ASR indicated suicide precautions may be discontinued, the youth was stepped down to close supervision prior to transition to normal routine/standard supervision. All follow-up ASRs included all required elements and the discontinuation of close supervision was documented, as required.

The parent/guardian and juvenile probation officer (JPO) were notified of the youth's potential suicide risk and an alert was entered and updated as required in the Department's Juvenile Justice Information System (JJIS). The ASR and all follow-up ASRs were completed and conducted by a non-licensed mental health clinical staff, which were subsequently reviewed by the program's DMHCA within twenty-four hours. The youth maintained on PO could participate in select activities with other youth in designated areas of the program. The youth was not limited to an individual cell or restricted to their room. The program has two suicide response kits, both in master control. Each of the suicide response kits contains a knife-for-life, wire cutters, and needle nose pliers. The program's written suicide prevention plan, written mental health crisis intervention plan, and written emergency mental health and substance abuse services plan addresses the review process for every serious suicide attempt or serious self-inflicted injury and mortality review for a completed suicide. A multidisciplinary team review includes circumstances surrounding the event, facility procedures relevant to the incident, all relevant training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations, if any for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures. All five interviewed staff responded they would notify either mental health staff, medical staff, or the supervisor should youth express suicidal thoughts. Five interviewed staff were able to identify the location of the program's suicide response kits.

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

The review of five youth records found one youth had been placed on suicide precautions which was applicable for the completion of Suicide Precaution Observation Logs, since the last annual compliance review period. There were nine days and eighteen logs available for review for this youth. Fourteen of the eighteen 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 (PO) Logs also had all required reviews by supervisory staff and licensed clinicians.

One of the remaining four PO logs did not have the safe housing box checked, another PO log had the date and time of the observation but was missing the staff's initials, another PO log did not indicate the location or area of the safe housing, and on another PO log the shift supervisor's review did not have the time next to the signature. In the facility logbook, on one shift, on April 15, 2020, the shift report alert status did not indicate the name of the youth under PO; however, the alert status did state one youth was under PO. Clear instructions were provided for staff regarding how the 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 review period. The youth indicated staff were with them always during this placement and the youth was 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 nine of the ten records 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 remaining one staff pre-service record was not applicable, since the staff is the human resource coordinator and is also located off-site. The program's mock suicide drills were reviewed since the last annual compliance review, which included the first two quarters of calendar year 2020. Each of the reviewed drills included the time of the drill, the designated shift, name of the individual 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. All staff participated in at least one reviewed drill and any staff unable to attend a drill were able to review the drill scenario during monthly staff meetings. The drills during the first and second quarters of 2020 were all found to include a demonstration of cardio-pulmonary resuscitation (CPR). The facility administrator's interview confirmed staff are provided training and mock drills in suicide prevention which includes emergency response to suicide attempts or self-inflicted injury, 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 written crisis intervention plan which outlines how staff shall respond to youth in crisis in the least restrictive means possible to protect the safety of youth and others, while maintaining control and safety of the facility. The crisis intervention plan includes all required components including notification and alert system, means of referral, including youth

self-referral, communication, supervision (one-to-one, constant, close, and standard supervision), documentation, and review.

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

The program has a policy and procedures addressing crisis intervention services. Procedures state staff should utilize the Department's Crisis Assessment form when engaged in a crisis intervention. None of the five original youth were applicable for Crisis Assessments; therefore, the program provided one additional applicable youth record. In reviewing the record in the one instance, the youth was seen within two hours of being determined to be in crisis. The provided assessments included the reason for the assessment, a mental status exam and interview, the determination of danger to self and/or others, clinical impressions, and recommendations for supervision, treatment, and follow-up for further evaluation. The supervision was documented on a Mental Health Alert Log and an alert was entered in the Department's Juvenile Justice Information System. 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 which was completed in the reviewed assessment. The 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 time frame.

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 executive director and the designated mental health clinician authority (DMHCA) on June 22, 2020 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 to include mock drills, Baker Act and Marchman Act, and program administration review of 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 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 designated health authority (DHA) is a licensed osteopathic physician who holds an unrestricted license and meets all requirements for independent and unsupervised practice in Florida, which expires on March 31, 2022. The physician's specialty training is in internal medicine. The DHA is on-site at least once a week, for a minimum of 2 hours. A review of documentation for the past twenty-eight weeks reflected the DHA is on-site once a week for two hours Sunday through Saturday, and available twenty-four hours a day, seven days a week. If the DHA is on vacation or scheduled absence, coverage is arranged with another doctor of equal licensure in the State of Florida whose license expires on January 31, 2021; however, the DHA would still provide the administrative duties. The DHA is responsible for communication with program staff regarding youth medical needs, acute medical concerns, emergency care, and coordination of off-site care. There were no disciplinary cases or public complaints on record for both the contracted DHA or covering doctor.
The DHA was interviewed and confirmed being on-site every week. The DHA further described their role to include performing Comprehensive Physical Assessments upon youth admission, conducting periodic evaluations every sixty days, and reviewing and following all policies and procedures. The DHA is available by telephone twenty-four hours a day, seven days a week.

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

The designated health authority (DHA) and facility administrator signed and dated all respective treatment protocols and medical facility operating procedures (FOPs). Nursing staff signed and dated a cover page on which all medical FOPs, treatment protocols, and other procedures are listed. New policies, or changes in polices, are reviewed, signed, and dated by each nurse on the individual policy when changes occur between annual compliance reviews. A review of orientation documentation for new healthcare staff was conducted. All newly employed healthcare personnel received a comprehensive clinical orientation to the Department's healthcare policies and procedures, which is given by a registered nurse. Approval of treatment protocols. or standing procedures, were written and authorized by the DHA and were not delegated to any other person. The review and development of FOPs or other protocols related to psychiatric services and psychotropic medication management is only performed by the program's psychiatrist. A review of the program's health-related policies, procedures, and protocols indicated they were reviewed and approved by the appropriate provider and outline the program's healthcare services.

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

Five youth Individual Healthcare Records (IHCR) were reviewed. Each IHCR had a signed Authority for Evaluation and Treatment (AET) form stamped with the word "Copy" in red ink.

One youth turned eighteen years old after admission to the program and a form for release of information was completed. Two additional youth who turned eighteen after admission were also reviewed and both had a form for release of information completed.

Three additional youth IHCRs were reviewed for youth who are in the care of the Department of Children and Families (DCF) and all three had court authorization for treatment. Copies of completed parental notifications were maintained behind the AET form in all five IHCRs. The AET form is printed from the Department's Juvenile Justice Information System (JJIS) prior to admission. In an interview with the nurse, it was stated if an updated AET is needed or court order from the court for the DCF youth, the juvenile probation officer is contacted.

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. Five youth individual healthcare records (IHCRs) were reviewed. Three IHCRs were applicable for and contained documentation of parental notifications for over-the-counter (OTC) medications beyond those covered by the Authority for Evaluation and Treatment (AET) form. Additionally, four of the five youth IHCRs reviewed found notifications were sent, as needed, for issues such as the discontinuation of medication prescribed prior to youth entering custody, changes in conditions/medications for youth with chronic conditions, non-routine dental procedures, and for new medications. Nursing staff stated the parent/guardian is called in addition to sending out a written consent to be signed and returned.

Documentation of the verbal contact along with a witness, is noted on the chronological nursing notes and the copy of the mailed consent is stored in the youth's medical record. The nurse further stated verbal and written notifications are made when giving a medication not listed on the AET form, for significant medication changes, and when going off-site for an appointment or an emergency. Four of the five reviewed youth IHCRs were applicable for psychotropic medication. Three youth had a Clinical Psychotropic Progress Note (CPPN) reflecting parent/guardian consent on page three and the fourth youth was eighteen years of age and did not require parental contact. All five reviewed youth IHCRs indicated youth admitted to the program had their immunization records verified within thirty days of admission through the Florida Shots website and school records. There were no youth applicable for off-site emergency care at the time of the review. None of the five selected youth were in the care of the Department of Children and Families at the time of the review. None of the youth reviewed were applicable for refusing consent due to religious reasons.

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 has a policy and procedures in place ensuring each youth will receive a screening for health concerns upon admission, or at a minimum, each time the physical custody of the youth changes and they are returned or readmitted to the program. Five youth Individual Healthcare Records (IHCR) were reviewed for completion of a Facility Entry Physical Health Screening (FEPHS) form. Documentation in all five IHCRs reflected a FEPHS form was

completed by a registered nurse (RN) on the day of admission to the program. None of the five reviewed youth IHCRs indicated a change in physical custody greater than twenty four hours.

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 has a written policy and procedures to ensure the healthcare admission screening includes health orientation education to each youth admitted to the program. Five youth Individual Healthcare Records (IHCR) were reviewed for healthcare orientation. Documentation in each of the five IHCRs reflected the youth received healthcare services orientation on the day of admission. The program's healthcare orientation included access to medical care, sick call, what constitutes an "emergency" and when to notify staff, medication process to include side effect monitoring, the right to refuse care, what to do in the event of sexual assault or attempted sexual assault, and the non-disciplinary role of healthcare providers. A signed and dated receipt of healthcare orientation was observed in all five IHCRs reviewed.

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

The program's practice is to notify the designated health authority (DHA) for all admissions to the program. All five reviewed youth Individual Healthcare Records (IHCR) contained documentation reflecting the DHA was notified by telephone for each youth upon admission to the program. The DHA notification was documented in the chronological progress notes in the IHCR in each record.

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). Five youth Individual Healthcare Records (IHCR) were reviewed for completion of a Health-Related History (HRH) form. In all five IHCRs reviewed, a new HRH form was completed on the day of admission by a registered nurse (RN). There was indication on the Comprehensive Physical Assessment (CPA) of the designated health authority (DHA) reviewing the HRH form. All five HRH forms were completed prior to the CPAs.

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

The designated health authority (DHA) completes a new Comprehensive Physical Assessment (CPA) for each youth within seven days of admission and annually, thereafter. The program utilizes the Department's CPA form. A review of five youth Individual Healthcare Records (IHCR) found a new CPA was completed within seven days of admission for all five youth. The

DHA completed each CPA and the medical grade was documented. Three youth were medical grade one and two youth were a medical grade five. Each CPA was completed in accordance with Department requirements. All sections of the CPA were marked with an "O" or an "X." Those sections marked with an "X" reflected comments by the DHA in the comments section of the form. The Department's Problem List was updated for the five applicable youth. The program has policy and procedures for tuberculosis screenings and rescreening process which were reviewed at the time of the annual compliance review. All five youth had at least one verified tuberculin skin test (TST) completed and documented within the last year. Each youth was assessed prior to being placed in the general population. Results of the TST were documented on the CPA and infectious communicable disease (ICD) forms in all five records reviewed.

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 Individual Healthcare Records (IHCR) indicated each youth was screened and evaluated for STIs. Documentation reflected all youth received a STI screening upon admission to the program. Testing, screening, results, clinical evaluation, and diagnosis were documented on the Infectious and Communicable Disease (ICD) form. None of the five youth reviewed were out of the Department's custody, thus none required a re-screen. Referrals for testing were documented on the STI screening form and in the progress notes upon admission. Documentation in all five youth reviewed IHCRs reflected youth were offered human immunodeficiency virus (HIV) testing, counseling, and treatment upon admission to the program. All five of the youth refused the HIV testing. A copy of the Polk County Health Departments 500/501 certification was available for review. Four of the five interviewed youth reported they could request a HIV test. The remaining youth stated they did not think they could request a 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.	

During the annual compliance review period, there were no youth who presented a similar sick call complaint three or more times within a two-week period. The program does have a policy and procedure in place which provides youth with the opportunity to voice healthcare concerns and be evaluated by a nurse to determine the severity of their concerns. None of the five reviewed youth Individual Healthcare Records (IHCR) indicated the youth presented with complaints in which medical staff were unfamiliar with. Completed sick call request forms were observed to be filed with the corresponding progress note for three applicable youth, in reverse chronological order. Sick call was completed by a registered nurse (RN). The program does not utilize restricted housing. The program conducts sick call daily as needed, sick call times were

observed posted throughout the program. In the event a nurse is not on-site to conduct sick call, the shift supervisor will review sick call requests within two hours and contact the designated health authority (DHA), if determined urgent in need. Progress notes were documented in accordance with Health Services Rule 63M-2. Sick calls were documented on individual youth Sick Call Indexes in the IHCR as well as the Sick Call Referral log. Sick call forms were observed to be available to youth throughout the program. There were no sick calls observed at the time of the annual compliance review. Three of the five interviewed youth stated they are seen immediately by the nurse if a sick call request is made, one youth stated within one day, and the fifth youth stated within three days. Five staff interviews indicated sick call is conducted by the nurse.

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.	

Five youth Individual Healthcare Records (IHCRs) were reviewed for episodic care. Three of the five youth IHCRs were applicable for episodic care. No youth was referred for off-site care. On-site care provided by licensed healthcare staff was documented in the subjective, objective, assessment, and place (SOAP) format in all three youth IHCRs reviewed. The episodic care log documents all instances of first aid/emergency care. Logs for the previous six months corresponded with all on/off-site events observed in youth records. Emergency medical and dental care including emergency medical services, are available twenty-four hours a day. The program has three first aid kits. First aid kits are in master control and medical. The three first aid kits were checked and each were fully stocked with the designated health authority (DHA) approved items. A review of documentation indicated first aid kits are inspected weekly by a registered nurse (RN), as indicated by first aid inspection forms.
The program has one suicide response kits which is located in master control. All suicide response kits contained the appropriate items such as knife for life, wire cutters, and needle nose pliers. The program has one automated external defibrillator (AED) which is in the main administrative hallway. Instructions are located inside the AED. The batteries expire in March 2022 and the pads expire in September 2024. The RN performed a self-test of the AED during the annual compliance review, which found to be operational. A review of drill documentation reflected the program has conducted drills monthly, and on each shift, as required. Additionally, drills included the use of cardiopulmonary resuscitation (CPR), AED, or the administration of first aid quarterly, also on each shift. The program has a list of emergency numbers including Poison Control Information Center, which are inaccessible to youth. The program has an approved list of non-licensed healthcare staff who can assist youth with medication administration or use of an epinephrine auto-injector. A review of training records for these staff indicated they have completed the required training. Five interviewed youth stated they can see the doctor or dentist if needed. Five interviewed staff stated they can call 9-1-1 if a youth has a medical emergency.

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 off-site 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. One youth Individual Healthcare Records (IHCR) reviewed was applicable for non-emergent off-site services. There were no additional off-site services to review since the last annual compliance review. The one record contained documentation of verbal and written parental notification for off-site care and included the completion of the Summary of Off-Site Care form. Discharge documents and instructions in the record was reviewed. The DHA's signature was observed on the Summary of Off-Site Care forms. There were no required follow-up appointments. Appointments are tracked by medical staff using an excel medical tracking sheet as well as transport logs, which are filed within the appointment calendar.

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.	

Three of the five youth Individual Healthcare Records (IHCRs) were applicable for chronic conditions. All three IHCRs reviewed were identified as having a chronic condition on the Facility Entry Physical Health Screening (FEPHS) form. None of the three youth reviewed had a communicable disease. All three youth were taking prescribed medication on an ongoing basis. All three of the youth were identified as having a chronic illness on the program's internal alert roster. The chronic conditions roster includes the due dates for each youth's next periodic evaluation. Documentation reflected all three youth received periodic evaluations every sixty days and there were no instances of lapses in care or missed periodic evaluations. All periodic evaluations were conducted on-site. The Department's Problem List for each youth was updated in accordance with the Health Service Rule 63-M. Evaluations are conducted prior to the renewal of a prescription medication about to expire. Treatment orders were observed to be written clearly for clinical staff. The facility administrator advised alerts are shared daily during management meetings and are posted in master control and dietary alerts are posted in the kitchen. The designated health authority advised medical utilizes a tracker for periodic evaluations and updated daily.

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

Five youth Individual Healthcare Records (IHCR) were reviewed for youth taking prescribed medication upon entry to the program. Prescription verification for youth taking medication upon entry to the program was documented in the chronological progress notes in all five IHCRs reviewed. Documentation reflected the registered nurse (RN) contacted the designated health authority (DHA) and psychiatrist to resume the medications. All medications were observed to have a current, valid order and were given pursuant to a current prescription. Each of the five youth were applicable for over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET). The OTC medications were administered in accordance with approved protocols. The program utilizes a pre-printed pharmacy Medication Administration Record (MAR). Documentation reflected both staff and youth initialed each administered medication. There were no undocumented explanations for lapses or errors in medication administration. Nursing staff document weekly side effect monitoring on the MAR.

The Six Rights of Medication Administration are maintained by both licensed and non-licensed staff. There were no instances of refusals. All medications were observed to be stored in separate, secure areas inaccessible to youth. Narcotics and other controlled medications are stored behind two locks. Oral medications are not stored with injectable or topical medications. Medications requiring refrigeration are stored in a secure refrigerator, which is used for medication only. Syringes and sharps are secured. The medication cart was observed to be clean, organized, and stock items are stored separate from specific youth medications. Expired medication is destroyed using Medication Disposal Container once a month according to the agreement with the pharmacist. Medication pass was able to be observed during the annual compliance review with no issues noted. All five interviewed youth reported the nurse gives out medication. Five interviewed staff indicated the nurse dispenses medications to youth. Three indicated the supervisor or any other trained staff could dispense medications, if needed.

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

The program has a written policy and procedures in place ensuring the appropriate storage of all medication and equipment classified as sharps. Medical equipment classified as sharps was securely stored and inventoried by using a perpetual inventory. All medications are identified and secured in the locked area designated for the storage of medications. Medications such as injectables, topicals, drops, and liquids were separated. All controlled substances were observed and maintained behind two locks, stored separately from other medications, and had a perpetual inventory. A shift-to-shift inventory count of all controlled substances was documented on the youth's individualized Controlled Medication Inventory Record. The program has a process in place for disposal or destruction of expired and discontinued medications. A perpetual inventory of all sharps and stock over-the-counter (OTC) medications was observed. The program maintains an approved list of supervisory level, non-healthcare staff trained in the delivery of medication self-administration in the event nursing staff is not on-site. The reviewer conducted observations of the registered nurse (RN) inventory of two youth medications, one being a narcotic/controlled medication, three OTC medications, and three sharps, all of which matched the perpetual inventory. Reporting criteria and procedures for inventory discrepancies are in place. Perpetual inventories of medications and sharps for the previous six months were available for review. According to the RN, medication inventory is completed weekly and daily. The RN explained medication is destroyed by the pharmacy and a medication disposal container. The RN added, controlled medication is stored in a locked box within the secure medication cart.

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 infection control procedures include prevention, containment, treatment, and reporting requirements related to infectious diseases, according to Occupational Safety and Health Administration (OSHA) federal regulation and the Centers for Disease Control and Prevention (CDC) guidelines. The program's infection control procedures include common, infectious diseases of childhood; self-limiting, episodic contagious illness; viral or bacterial diseases, tuberculosis, hepatitis A, B, C, and HIV; pediculosis and/or scabies, methicillin-resistant staphylococcus aureus (MRSA), food borne illnesses, bio-terrorist agents, and chemical exposure. Staff have access to protective equipment. The hepatitis B immunization is available to staff.
There were no instances in which the local health department, CDC, or the Central Communications Center (CCC) should have been notified. The program has a comprehensive process for needle stick post-exposure evaluation. The program director or designee will maintain a separate file containing all documents for youth and staff who have experienced facility exposure, as necessary. The program's exposure control plan was found to be written in accordance with OSHA standards. The plan is available to all staff. The plan is reviewed and signed annually by the program. The plan includes a risk assessment, methods of compliance, and process for needle stick post-exposure. According to the facility administrator, the plan is located within the facility operating procedures in a binder in master control.

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.

4.19 Licensed Medical Staff (Critical)	**Satisfactory Compliance**
The Designated Health Authority (DHA) is clinically responsible for all healthcare services provide to youth at the program. Daily clinical care shall be performed by licensed medical staff (RN, LPN) according to developed and authorized protocols. This includes the intake evaluations, assessments, health education, medication management and other assigned duties according DJJ Rule as well as Facility operating procedures and nursing protocols approved by the DHA.	

The program utilizes a registered nurse (RN), whose license is clear and active, as the Health Services Administrator (HSA) with a license expiration date of April 30, 2021. The HSA is responsible for the delivery of health services, supervision of personnel, and liaison services within the program. The HSA is to ensure the designated health authority signs in and out when on-site for required visits. The HSA is responsible for daily communication to program administration on important medical issues pertaining to youth at the program. The HSA has been certified in cardiopulmonary resuscitation .

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.	

Documentation reveals the program has a written policy and procedures for active supervision of youth. According to the written policy and procedures, staff-to-youth ratios are one-to-seven during awake hours and one-to-nine during sleeping hours. Observations, informal interviews, logbook entries, and video reviews confirmed staff-to-youth ratios were in compliance. Staff were able to immediately communicate to the annual compliance review team member how many youth they were supervising when questioned.

During the annual compliance review, youth were observed reading educational materials and attending scheduled Zoom classes with teachers as scheduled and participating in meals, breaks, and line movements. Positive interactions were observed between youth and staff. The posted schedule was full of activities. Observations throughout the review week found the schedule was followed. At no time during the annual compliance review, were youth observed wandering freely about the program. Five staff were interviewed and each confirmed their understanding of the procedures when there is a discrepancy with the count. All interviewed staff indicated the count is reconducted until the count is reconciled. Observations, informal interviews, logbook entries, and video reviews confirmed counts were conducted at scheduled and unscheduled times.

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

The program has a policy and procedures addressing the comprehensive and consistent implementation of the behavior management system (BMS) and staff training. Documentation confirmed the program has a detailed written description of the collaborative BMS. The program utilizes the BMS to foster accountability for behavior and compliance with the program's rules and expectations. The program's BMS consists of four levels, which are designed to positively reinforce pro-social behaviors and reduce anti-social behaviors. Each youth earns points, which are documented on a level system evaluation form. The BMS was observed to be posted on the living spaces and is clearly explained in the program's handbook which is accessible to youth. The program's BMS details the rules and the positive and negative consequences for actions. Five pre-service and five in-service training records were reviewed and each contained documentation of BMS training. All five interviewed staff confirmed training and their understanding of the BMS. Informal interviews with staff during the annual compliance review week, confirmed their understanding and implementation of the BMS.

The orientation checklist documents the BMS is reviewed with the youth. All youth case management records contained a complete orientation checklist. The BMS promotes youth rights, positive, negative consequences, constructive disciplinary action, opportunities for reinforcement, and provide youth with pro-socially acceptable alternative behaviors. The youth have an opportunity to explain their behavior. The BMS is connected to the youth's individual performance and treatment plan goals. 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. The facility administrator interview confirmed the BMS is a level/point system with daily and weekly incentives. All five interviewed youth confirmed their understanding of the BMS.

The program provides opportunities for positive reinforcement and recognition of accomplishments and positive behaviors at a minimum ratio of four-to-one positive to negative consequences. Five youth were interviewed and all five rated the BMS as being very good. Five interviewed staff were able to summarize the BMS process, as well as provide examples of rewards and incentives given to youth. All five staff indicated only privileges can be taken away from youth as a result of negative behaviors exhibited.

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 the behavior management system (BMS) infractions and system monitoring. A review of the program's written policy and procedures for the BMS ensured there was a protocol where staff are provided feedback regarding their implementation of the BMS. Documentation confirmed feedback is delivered through monthly staff meetings, on-going training, and performance evaluations. Five staff training records were reviewed. All five staff received pre-service and in-service training for the BMS. A review of position descriptions confirmed they specified the required qualifications of staff whose job functions include implementation of the program's BMS. The qualifications varied by position from high school diploma to college degrees. The program's BMS includes a process wherein staff explain to the youth the reason for any sanction imposed.

A review of the provider's contractual agreement confirmed all required parties were involved in the development, implementation, and on-going maintenance of the BMS. The program does not utilize room restriction, as indicated in their policy. The BMS does not include increased length of stay, denial of youth basic rights, promotion of group punishment, punishment by other youth, or disciplinary confinement. Education staff are paid for through the provider and are trained by the facility administrator (FA) on the BMS.

Five interviewed staff were able to summarize the BMS process. The program utilizes several methods to ensure the BMS is used fairly and effectively. These methods include monitoring point cards during treatment meetings, discussing the use of point cards during monthly supervisor's meetings, and daily staff debrief sessions. This ensures the system is not being used to increase a youth's length of stay. When a youth disagrees with points assigned or lost, the point cards are reviewed by the FA with the youth and staff present.
All five staff indicated only privileges can be taken away from youth as a result of negative behaviors exhibited. All staff explained youth are informed of the consequences and can explain their behaviors. Each of the five interviewed staff indicated they received feedback on their implementation of the BMS daily and as needed. Five youth were interviewed concerning the staff's implementation of the BMS. Five youth explained staff were consistent. The FA interview confirmed consequences are monitored during the morning management meeting, as well as during special and regular treatment teams. The program's BMS is not used solely to increase a youth's length of stay. Behaviors, positive and negative are reviewed during treatment teams.

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. Documentation indicates the program has twenty-nine cameras. Twenty-nine cameras were operational and providing coverage at the time of the annual compliance review. The video coverage storage provides thirty days of recording. The program's practice is to conduct checks every eight minutes. A review of ten different shifts each for one hour, was conducted to monitor ten-minute checks. All ten shifts were included in the video reviewed. All reviewed checks were completed within the ten-minute window and most were completed eight minutes apart. Video logs confirmed the checks were completed and documented at the correct intervals. Each of the five interviewed staff indicated checks are completed at eight-minute intervals.

5.05 Census, Counts, and Tracking	Satisfactory Compliance

The program ensures youth are accounted for at all times through a system of physically counting youth at various times throughout the day.

The program shall conduct and document resident counts minimally at the beginning of each shift, after each outdoor activity, and during emergency situations such as escapes or riots.

The program shall maintain a chronological record of events as they occur, or, if an event disrupts the safety and security of the program, as soon as is feasible after order has been restored.

The program tracks daily census information, including, at a minimum, the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program. If at any time staff cannot account for the whereabouts of any youth, or discrepancies are found between resident counts and census information, the program reconciles immediately and takes follow-up action as needed.

The program has a policy and procedures addressing census, counts, and tracking. Documentation confirmed youth are always accounted for through a system of physically counting youth at various times throughout the day in accordance with the program's policy and procedures. The program tracks in the logbooks daily census information including the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program.

The logbooks were reviewed and the sampling included a random date selected for January, February, March, April, May, June and July 2020. All three shifts were reviewed for each random date and no discrepancies were found. Informal and formal counts were observed during the annual compliance review and found they were each conducted, as required. Five staff interviews confirmed staff were knowledgeable of the procedures for reconciling the count if there is a discrepancy. Staff also indicated counts are conducted at the beginning of each shift, after outside activities, and during major disruptions.

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 to address logbooks. Logbooks from a random sample of one day each on each shift from January 2020 to July 2020 were reviewed, as well as all three shift reports for those dates. All shift reports were signed and dated by incoming staff to confirm they reviewed the report or were verbally briefed on the contents. All the logbooks were bound. All entries were in ink. There was no evidence of eraser marks. None of the pages were removed or obliterated. Each logbook covers a one-month period. The logbook pages documented perimeter checks, weather alerts, Central Communications Center (CCC) reports, shift summary notes, keys, radios, drills, Prison Rape Elimination Act (PREA) checks, fire safety, scheduled and unscheduled counts, and any calls made to the Florida Abuse Hotline and the CCC.

All reviewed entries included the date and time of event, the name of staff and youth involved, a brief description of the event, and the name and signature of the staff making the entry. The program does not maintain a living unit logbook. Three CCC incidents on March 2020 were reviewed. Documentation confirmed these incidents were reported to the CCC and one was noted in the logbook. The remaining two incidents were not noted in the logbook due to confidentiality.

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. Documentation confirmed the program has a system to govern the control and use of keys. The program's written policy and procedures address distribution, tracking, storage, and overall control and security of keys. A review of the inventory matched the key rings in use. The keys are stored in a secure area in the master control area, which is not accessible to youth. Each set of keys has an assigned key hook. Keys are assigned to staff according to their department. The master control operator reported the restricted keys, temporary keys, and visitor keys are all stored separate from one another. There were no reports of broken or damaged keys. There were no incidents of lost keys which was verified by a review of internal incident reports and Central Communications Center (CCC) reports. The maintenance manager is responsible for replacing broken or damaged keys. Informal interviews with staff confirmed staff's knowledge of the key rings and assigned keys.

All observations during the annual compliance review found personal keys were secured and staff were aware of program keys in their possession and followed the key control procedures. A sampling of three staff's keys was completed to compare their key rings to the key inventory logs with no issues identified. All five interviewed staff confirmed staff knowledge and implementation of key control policies and procedures. Additionally, staff reported if keys were damaged, they would notify their supervisor and submit a maintenance request.

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 key control. Documentation confirmed the program has a system to govern the control and use of keys. The program's written policy and procedures address distribution, tracking, storage, and overall control and security of keys. A review of the inventory matched the key rings in use. The keys are stored in a secure area in the master control area which is not accessible to youth. Each set of keys has an assigned key hook. Keys are assigned to staff according to their department. The master control operator reported restricted keys, temporary keys, and visitor keys are all stored separate from each other. There were no reports of broken or damaged keys. There were no incidents of lost keys, which was verified by a review of internal incident reports and Central Communications Center (CCC) reports. The maintenance manager is responsible for replacing broken or damaged keys. Informal interviews with staff confirmed staff's knowledge of the key rings and assigned keys.

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5.09 Searches and Full Body Visual Searches	Satisfactory Compliance

The program shall perform searches to ensure no contraband is being introduced into the facility.

Documentation confirmed the program has written policy and procedures addressing searches and full body visual searches. Observations during the annual compliance review, found searches were completed prior to and after movement from one area to another. Observations found searches were conducted in a manner which treated the youth with dignity and respect. Searches were conducted in accordance with the Protective Action Response (PAR) training manual. Five staff were interviewed and indicated all searches are conducted by the same gender as staff for all movements throughout the day. Full body visual searches are completed

for admissions or youth returning from off-site activity. Five youth were interviewed and indicated searches are conducted when returning from off-site, after outings, meals, visitation, recreation, and work details.

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 has three vans which two are operational. The third van is non-operational due to an air conditioner issue. Each van had an annual safety inspection completed in 2020. All three vans observed were secured when not in use. Two random checks on two separate days also confirmed the vans are secured when not in use. All staff personal vehicles were also checked and were all secured. All three vans contained a fire extinguisher, seat belt cutter, window punch, and appropriate number of seat belts. 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. The program's written policy and procedures were reviewed and found to ensure compliance of all requirements outlined by the Department relating to transportation of youth and driver eligibility (FDJJ 1920). The program's policy and procedures addressing transportation of youth include the use of mechanical restraints for youth being transported. Driver's license checks are conducted annually by the administrative assistant to ensure all staff have a valid Florida driver's license. Transport vehicles are searched prior to transport and upon return to ensure no contraband is present.
An observation of a transport was conducted and confirmed the staff-to-youth ratio was within the requirements and there was staff of the same gender as the youth being transported. Observations of facility transport vehicles indicated each of the van doors were locked when not being used. Random staff vehicle checks confirmed the vehicles were locked. Five youth were interviewed and reported they all feel safe and wear seatbelts. All five interviewed staff confirmed youth are not transported in staff's personal vehicles. Staff indicated they are provided a facility-issued cellular phone while on transports. Staff interviews also indicated they take facility-issued cellular phones on transports to allow for communication with 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 audits. The written policy and procedures clearly designate the maintenance manager for conducting the weekly safety and security audits. The weekly audits binder was reviewed and confirmed the program completes a weekly Facility Security Audit and Safety Inspection form consistently listing deficiencies on the back page. The form documented safety and maintenance repairs needed and the date and time the repairs were completed. The weekly safety audits are stored in a binder. All the forms were reviewed and signed by the facility administrator (FA). The forms cover radios, cameras, keys, telephones, mechanical restrains, generator, flashlights, fire safety equipment, alarms, ensuring no anchor points, youth rooms, recreation area, grounds, correction action needed, and corrective action completed. A review of weekly safety audits revealed they are being completed every seven days. The interview completed by the FA confirmed the weekly safety audits are conducted in accordance with program policy and procedures.

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 written policy and procedures in place to ensure youth use tools safely and are supervised appropriately to prevent injuries to the youth, other youth, and staff. The only tools on campus are Class B tools which are securely stored in the laundry room. The inventories and sign-in-sheets for the previous six months were reviewed. All the Class B tools matched the inventory. All observations during the annual compliance review found Class B tools, mops, and brooms were secured when not in use. Five youth were interviewed and indicated they only use brushes and mops. Five staff interviews confirmed youth do not have access to any unapproved tools.

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

The program has a policy and procedures to ensure youth tools handling is safe and are supervised appropriately. A review of five youth records confirmed youth are given an assessment to determine the level of tool access. The assessments were completed during the monthly treatment team meetings. Five youth were interviewed and indicated they do not have access to any tools without supervision.

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

Documentation reveals the program has written policy and procedures to address when an outside contractor enters the program to perform a work project requiring the use of tools. The program restricts tools to those necessary, checks tools upon the contractor’s arrival and

departure, restricts youth access to the work area, ensures immediate reporting of any tool the worker cannot locate, and follows up if any tool is missing. Personal cellular phones and/or equipment/electronic devices capable of taking pictures and/or audio/video recordings are prohibited in the secure area. The program maintains a binder which contains all notice of tool equipment instructions forms which the outside contractor must sign. The binder was reviewed and the dates of the work invoices matched the sign-in sheets of the outside contractors. The tool notice forms also address when tools are checked upon arrival and departure, tool restrictions while in the facility, youth are restricted from the work area, and missing tool follow-up. Outside contractors are required to sign the notice of tool equipment instructions form.

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. Drills are conducted in accordance with the program's disaster plan or Continuity of Operations Plan (COOP). A review of the fire, safety, evacuation, and disaster drills between January and July 2020 was completed. All the drills contained the type of drill, date and time, participants, brief scenario, and findings and recommendations. Fire drills were conducted three times a month ensuring all shifts participate, exceeding the required monthly drills. Additionally, other safety, evacuation, and disaster drills, covering natural disasters and evacuations were completed within the past twelve months. An interview with the facility administrator confirmed the program have at least three fire, safety, and evacuation drills, monthly. Five staff were interviewed and confirmed fire, safety, and evacuation drills were conducted on a monthly basis. Five youth were interviewed and confirmed they have been instructed on the fire evacuation process. Fire evacuation routes and egress plans were posted throughout the facility. In addition, all of the fire extinguishers are inspected annually.

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 Continuity of Operations Plan (COOP) is located in master control and in the facility administrator's (FA) office. The plan addresses alternative housing plans approved by the applicable Department regional director/designee. The plan was approved by the residential regional director on March 12, 2020. The COOP addresses fire prevention and evacuation, severe weather, disturbances or riots, bomb threats, hostage situations, chemical spills, flooding, terrorist threats or acts, staff roles and responsibilities, any equipment and supplies needed, information about youth which may be needed, alternative housing arrangements, provisions for continuity of care and custody of youth, and provisions for public protection. The program conducts COOP drills on each shift. The drill documentation included

the type of drill, date and time of the drill, participants, brief scenario and findings/recommendations, and pictures. The drills included natural disasters, disturbance, chemical spills, active shooter, and evacuation severe weather. The program maintains critical identifying information for each youth in an administrative hard-copy file which is easily accessible and mobile in the event of an emergency situation. The program has food and necessary supplies readily available in case of emergency evacuation. The FA reported the COOP is located in master control and in the FA's office. Supplies required for continuous operation and services during an emergency or disaster situations are located in a secured closet in the kitchen.

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 to ensure inventory and strict control is maintained over flammable, poisonous, and toxic items and materials. The safety data sheets (SDS) and current storage of poisonous, flammable, and toxic materials were observed. All flammable, poisonous, and toxic items were secured in a locked shed within a locked fence, outside the facility. Poisonous items inside the facility were stored in a locked cabinet, inside the locked laundry room, and were clearly marked on the inventory sheets with the attached SDS sheets which were accurate and current. Documentation confirmed the program's Preventive Maintenance Checklist was reviewed and the program is adhering to their maintenance schedules and repairs are being conducted.

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. The program maintains strict control of flammable, poisonous, and toxic items and materials. The program's policy and procedures indicated youth are not allowed to use or have access to chemicals. Observations throughout the annual compliance review confirmed youth do not use or have access to the chemicals. Five youth were interviewed on the use of these materials. Each of the interviewed youth reported they do not use any chemicals. All five interviewed youth reported they do not use chemicals. Documentation confirmed the program's Preventive Maintenance Checklist was reviewed and the program is adhering to their maintenance schedules and repairs are being conducted.

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 to ensure the maintenance mechanic has the safety equipment and procedures for handling and disposing of hazardous waste and/or solid waste and toxic materials. All hazardous material inside the shed and cabinet had the required safety data sheet (SDS), according to standard requirements. The facility administrator and the maintenance mechanic stated the maintenance mechanic takes all hazardous materials to the local waste management site to properly dispose of hazardous items, toxic substances, and chemicals in accordance with Occupational Safety and Health Administration (OSHA). The program reported there were no instances in which the program disposed of chemicals since the last annual compliance review.

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

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

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

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

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

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

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

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

The program has a policy and procedures addressing visitation and communication. The visitation procedures are posted on the front gate and on the wall in the lobby. The visitation and communication procedures are covered in the resident handbook and addressed on the orientation checklist. A review of the visitation, mail, and telephone log and schedule was conducted to confirm the program's practice. Youth are given an opportunity to communicate with family members through visitation, mail, and telephone calls. Searches of incoming and outgoing mail is completed by staff in the presence of youth. Each youth receives a youth handbook upon admission which details visitation, telephone, and mail procedures. Five interviewed youth all reported they have the opportunity to communicate with their families through these means. The weekly telephone calls to parent/guardians are documented in the youth case management records in the chronological notes. Five youth case management records were reviewed. All contained documentation of weekly telephone calls to parent/guardians or family members. Each of the five interviewed youth confirmed they have opportunities to contact their family by telephone and during visitation. Documentation revealed the program ceased visitation between the periods of March 13, 2020 to June 20, 2020 due to the COVID-19 pandemic emergency policies. It was briefly resumed from June 20, 2020 to July 8, 2020 and has ceased again since July 8, 2020.

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.