STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Brevard Group Treatment Home

Aspire Health Partners
(Contract Provider)
3905 Grissom Parkway
Cocoa, Florida 32926

Review Date(s): April 21 - 24, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Bonita Williams, Office of Program Accountability, Lead Reviewer, Standard 1
Teresa Andersen, Office of Program Accountability, Deputy Regional Supervisor, Standard 5
Paul Czigan, Office of Program Accountability, Regional Monitor, Standard 3
Tamara Mahl-Adkins, Office of Program Accountability, Regional Monitor, Standard 4
Gustavo Mazorra, Office of Program Accountability, Regional Monitor, Standard 2
Amanda Nelson, Office of Program Accountability, Regional Monitor, Interviews
Jonathan Thompson, Office of Program Accountability, Regional Monitor, Interviews

Program Name: Brevard Group Treatment Home
Provider Name: Aspire Helath Partners
Location: Brevard County / Circuit 18
Review Date(s): April 21 - 24, 2020

MQI Program Code: 571
Contract Number: R2109
Number of Beds: 30
Lead Reviewer Code: 148

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
5.26 Safety Planning Process for Youth	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Youth Supervision *	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	Ten Minute Checks *	Satisfactory
5.05	Census, Counts, and Tracking	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	Satisfactory
5.24	Controlled Observation	Satisfactory
5.25	Controlled Observation Safety Checks and Release Procedures	Satisfactory
5.26	Safety Planning Process for Youth	Limited

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Program Overview

The Brevard Group Treatment Home is a 30-bed program, for twelve to fifteen year old males, located in Cocoa, Florida. The program is operated by Aspire Health Partner, Inc, through a contract with the Department. The program provides the Mental Health Overlay Services to youth. In addition, the program fosters each youth by providing life skills training, Impact of Crime (IOC), Young Men Work (YMW), Moral Reconation Therapy (MRT), Restorative Justice and gang intervention/prevention services. Additional treatment services provided includes individual, family, group therapy and recreational therapy. Program administration is comprised of a program director, two program managers, one administrative assistant. Case management services are provided by one case manager and one transitional service manager. Mental health staff at the program includes one designated mental health clinician authority, one clinical manager, three senior youth counselor's and one recreational therapist. Medical services are offered five days a week from 7:30 a.m. to 7:30 p.m., as needed on Saturdays, and 2:30 p.m. to 7:30 p.m. on Sundays and are provided by one designated health authority, one advanced practice registered nurse, one register nurse and one licensed practical nurse. Educational services are provided by the Brevard County Public School System. The layout of the program includes: one building which houses the dorms, nursing office and mental health offices, one building which house the administration offices, education, and the dining hall. The program has thirty operating security cameras providing coverage. At the time of the annual compliance review, the program had ten vacant positions; one registered nurse and nine direct care staff.

Standard 1: Management Accountability

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

The program has a policy and procedures in place regarding the provision of background screenings for all newly hired employees. The program had six new employees eligible for a background screening during the annual compliance review period. Each employee was found to have an eligible background screening in the Agency for Healthcare Administration (AHCA) Clearinghouse system which was completed prior to each staff's hire date. A review of each staff's personnel records found the program reviewed each staff's criminal history report, Staff Verification System (SVS) report, Florida Department of Law Enforcement (FDLE) Automated Training Management System (ATMS), and Central Communications Center (CCC) Person Involvement report prior to hire. All six staff were eligible for and had documentation in their records indicating they completed and passed a pre-employment assessment tool. None of the newly hired staff required an exemption prior to working with youth and did not have a break in service indicated in the SVS. A review of the program's volunteer roster and sign-in logs verified the program did not have any volunteers or mentors which required a background screening. The program did not employ interns during the annual compliance review period. The program utilizes teachers which are Brevard County Public School System employees. An Affidavit of Compliance with Level 2 Screening Standards was submitted to the Department on January 22, 2020.

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

The program has a policy and procedures in place regarding the provision of a background rescreening every five years of employment for all staff. A review of the employee, volunteer, mentor, and intern roster found the program had two staff applicable for a background rescreening during the annual compliance review period. Each staff was found to have a completed and eligible background screening in the Agency for Healthcare Administration (AHCA) Clearinghouse system prior to the five-year anniversary date.

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

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

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

The program has a policy and procedures which outline the provision of an abuse-free environment for youth and staff. The policy outlines the requirements of staff to offer youth unhindered and immediate access to the Florida Abuse Hotline by facilitating the youth's request to make a call as soon as possible with no screening. The policy further states staff have the ability and responsibility to call immediately if they suspect abuse. Observations made during the program tour found the program has postings for the Florida Abuse Hotline, as well as contact information for the Central Communications Center (CCC) for youth over the age of eighteen, throughout the program. The program completed a Trauma Responsive and Caring Environment (TRACE) self-assessment and documentation found the program used the results of the assessment to incorporate trauma-responsive principles into the program planning process. However, the TRACE document did not include date and name of program, it was clear after reading the content the information was in regard to the program specifically. A review of five pre-service and five in-service staff records found each had a signed code of conduct in their personnel records, as well as an acknowledgement of the employee handbook which further outlines the code of conduct for all staff. An interview with the program director indicated in the event of a critical offense, an immediate discharge occurs. The program had three incidents related to alleged physical abuse since the last annual compliance review. Of the three incidents, only one was found substantiated and the program terminated the staff involved. Five of the staff interviewed were able to explain the process to allow both youth and staff to call the Florida Abuse Hotline. Each of the staff reported never observing a co-worker deny a youth a call to the Florida Abuse Hotline or use profanity toward a youth. Each of the five interviewed youth reported feeling safe in the program. None of the five youth reported being stopped from calling the Florida Abuse Hotline. All the youth reported staff are respectful when speaking to youth. Four of the youth indicated never hearing staff use curse words; one youth reported hearing staff use curse words once.

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

The program had three allegations of abuse during the annual compliance review period, one of which were substantiated and warranted management response. Documentation was found indicating internal investigations were completed for each of the three applicable incidents. For the one incident, which was found to be substantiated for physical abuse, the staff involved were terminated. The documentation supported management took immediate action to address each of the incidents. The program director indicated during an interview, staff and youth are given instructions during monthly staff meetings and during the in-house meetings on how to properly notify the Florida Abuse Hotline. The director reported not having any allegations of abuse toward youth.

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

The program has a policy and procedures outlining a formal, internal and confidential system for reporting incidents of possible abuse. The program had three incidents which were reported to the Central Communications Center (CCC) during the annual compliance review period, which did not reflect an increase since the last annual compliance review. During the annual review, the program had a total of five CCC's. Three of the CCC incident reports were reviewed and found each incident was reported to the CCC within the required timeframe. Each of the CCC calls was found documented in the program logbook. A review of internal incident reports and grievances found no additional incidents which should have been reported to the CCC. The program director indicated during an interview, the CCC is called within two hours of the incident. If a youth wants to call the Florida Abuse Hotline, the call is made with the director or designee.

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

The program has a policy and procedures on the use of Protective Action Response (PAR) techniques for staff to utilize to maintain control of youth. The program's Protective Action Response (PAR) Plan was submitted to and approved by the Department on January 28, 2020. The program had thirteen incidents during the annual compliance review period which required a PAR, which is an increase of three since the last annual compliance review. The program's PAR rate during the annual compliance review period was 3.16 which is above the statewide Residential PAR rate of 2.35. The program response to the increase in PAR's is naturally due to the temperament of the youth, "we had a number of new youth enter the program, which

disrupted the culture in the program and new incoming youth were very defiant, combative and more confrontational". The program submits monthly reports regarding PAR's for the last six months to the Department regional office. The program director indicated during an interview, the PAR reports are located in his office and monthly submission of PAR's is sent to the Department. Each of the five PAR reports reviewed found the report was completed by the end of the day. In one of the five reports, one of the staff involved, did not complete a statement. The remaining four reports included statements by all involved staff. Each of the five PAR reports reviewed contained a post-PAR interview which was completed within thirty minutes with the youth, and was reviewed by a supervisor, PAR trainer, and the executive director or designee within the required timeframes.

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

The program has a policy and procedures outlining training for all new employees before staff have contact with youth. The program has a pre-service training plan which was submitted to the Department on February 5, 2020. Documentation supported the instructors for the cardiopulmonary resuscitation (CPR), first aid (FA), automated external defibrillator (AED) trainings were certified to deliver the curriculum. All pre-service training was documented in the Department's Learning Management System (SkillPro) except CPR, FA and AED for one staff. There was documentation the staff completed the training. Five staff hired during the annual compliance review period were reviewed for pre-service training requirements and each completed over 120 hours of pre-service training. Two of the five staff completed essential skills training in cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), PAR, suicide prevention and intervention, emergency procedures, and child abuse reporting prior to contact with youth and within 180 days of hire. Three of the new hires were hired in February 2020; therefore, they have time to complete the required training. Each of the five staff completed training in ethics, Child Abuse Reporting, Suicide Prevention/Intervention, Prison Rape Elimination Act (PREA), and active shooter training. Each of the five staff completed all additional trainings outlined in the program's contract.

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

The program has a policy and procedures outlining annual training for direct care staff and supervisors. The program has an in-service training plan which was submitted to the Department on February 5, 2020. In addition, the program has an annual in-serve training calendar, which can be updated if needed. All staff employed at the program are found to be trained in Protective Action Response (PAR). All training was documented in the Department's Learning Management System (SkillPro) except PAR and active shooter training for each staff. The active shooter training was facilitated during a staff meeting and the PAR training was facilitated by a Department staff who did not enter this training in SkillPro. Each of the five staff had documentation of cardiopulmonary resuscitation (CPR), first aid, automated external

defibrillator (AED), ethics, active shooter and child abuse reporting. Four of the five staff completed PAR update training; however, one staff did not complete the PAR update training; this staff completed the PAR in 2020. Four of the five staff completed suicide prevention training except one staff who completed five of the required six hours. The program had two supervisors who were hired in May 2019 and August 2019. The supervisor hired in May completed seven of the eight required annual supervisory training and the second supervisor hired in August completed four of the eight hours of training.

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

The program has a policy and procedures outlining the grievance process. The grievance process includes an informal, formal, and appeal process. The entire process is to be completed within three days. The complaints will be discussed and resolved regardless of the circumstances and will be documented in and logged in the grievance binder. Each of the pre-service and in-service staff reviewed had training on the grievance process. The youth place their grievance in a box, the supervisor checks the grievance box daily and reviews the grievance with the youth. If the youth wants to proceed to the appeal phase the program director reviews the grievance with the youth. The program maintains a binder containing the grievances addressed in the last twelve months. Since the last annual compliance review, the program had one grievance. The grievance was resolved at the formal phase within the timeframe of three days. The program director indicated during an interview, grievances are available to youth and when a youth fills out a grievance the grievance is addressed within seventy-two hours. The grievances are handled by the program manager or clinical manager. Five interviewed youth indicated the grievances are located in boxes on the dorm and dining hall. The youth did not know the timeframes; however, able to explain the grievance process. Each of the youth indicated being able to request assistance in completing the form. Each of the five staff interviewed were able to explain the grievance process.

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

The program has a policy and procedures outlining staff providing delinquency interventions and the implementation of interventions for youth in the program. The program provides Moral Reconation Therapy (MRT) and Impact of Crime (IOC). The program has four staff with master's-level degrees and at least two years of experience with youth trained in either life skills training, MRT and IOC. Each of the interventions are evidence based. The program schedule includes allotted times for each of the groups to be held during the week. The program director indicated during an interview, work experience and education are considered to determine staff delivering curriculums. The curriculums consist of MRT and IOC. Youth are assigned groups based on their individual needs based on assessments. Five youth records were reviewed for

intervention services during the annual compliance review period. For each youth a delinquency intervention was identified as a priority need according to the Residential Assessment for Youth (RAY). Four of the five youth performance plans included this priority need; the fourth youth performance plan did not include the priority need. After this exception was identified, the program updated the youth's performance plan to include the priority need. Each of the five youth indicated participating in groups while in the program. Each of the five youth indicated participating in IOC and MRT while in the program, as well as, practicing the skills in the program.

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

The program has a policy and procedures outlining life and social skills intervention services. The services address communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management and critical thinking, including problem-solving and decision making. The program facilitates a life skills training which addresses middle school substance abuse prevention program which teaches social and self-management skills. The program has a daily schedule which includes allotted times for life skills training to be held weekly. A review of sign-in logs and evidence-based services in the Department's Juvenile Justice Information System (JJIS) confirmed youth are receiving life skills and social skills training. Each of the five interviewed youth indicated participating in life skills, anger management and social skills groups while in the program.

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

The program has a policy and procedures for restorative justice services for youth in the program. Restorative justice provides activities to assist youth in accepting responsibility for harm caused by their criminal actions and challenges them to recognize and modify irresponsibility thinking. The program provides guest speakers during events such as graduations; the youth complete community service hours through an organization called Walk in Water and groups are provided to discuss restorative justice services. The program maintains sign-in logs documenting youth participating in restorative justice activities or groups, such as Impact of Crime (IOC). The program's daily schedule includes allotted time for restorative justice activities to be conducted throughout the week. The program director indicted during an interview, guest speakers come and speak to the youth and participate in community service such as trash pick-ups and taking care of animals. The guest speakers provide videos, slides, documentaries and role playing for the youth.

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

The program has a policy and procedures regarding youth receiving gender-specific programming while in the program. The program provides Young Men's Work curriculum which targets the male population. This group is held weekly by the therapist. All youth participate in the group as evident of sign-in logs and progress notes. The daily schedule included allotted time for gender-specific programming to be held. The program director indicated in an interview, in addition to Young Men's Work, the nurses conduct groups to discuss male development.

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 indicating the program internal alert system is to be maintained on a consistent basis which will notify staff of any risk youth may have. Of the five youth reviewed, one was applicable; therefore, an additional two youth records were provided for review. Verification of alerts were conducted and confirmed the Juvenile Justice Information System (JJIS) and the internal alerts matched. Each of the youth were removed or downgraded by appropriate staff. For one youth, the alerts were entered by the detention center and were not removed by the detention center; the program reported they will contact the detention center to close the alert since the program did not enter the alert. Five interviewed staff indicated they are informed of alerts through the internal alert form and shift briefing. The program director indicated in an interview, the nursing staff has their own internal alert which is distributed daily. The program director indicated medical, clinical and case management are responsible for entering and closing alerts in the JJIS.

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 has a policy and procedures regarding confidential youth records to include health, mental health, substance abuse, and other related treatment for each youth in the program. The program separates youth records into three separate records: individual healthcare record,

mental health/substance abuse record and case management. Each of the records contained on the tab the youth's name, Department of Juvenile Justice identification number, date of birth, county of residence and committing offense. Each of the youth records contain the following sections: legal information, demographic/chronological information, correspondence, case management/treatment team activities and miscellaneous. All the youth records had "confidential" on the front and were in locked/secured offices.

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

The program has a policy and procedures for providing youth opportunities to provide input in the rules and operation of the program. The program director indicated in an interview, bi-weekly dormitory meetings are held to discuss ideas, suggestions or concerns pertaining to the program. In addition, there is a student council and request forms to put ideas in writing. The program provides youth with a youth program update/input report. This report includes a section where youth can make suggestions on ideas to make the program better, to make their time at the program better and areas to improve on. The youth program update/input report is filled out by youth on a monthly basis. In addition, the youth are allowed to verbally make suggestions during daily meetings and directly to staff. Five youth indicated being able to provide input into what happens in the program through "Need to Talk" forms and youth council.

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

The program has a policy and procedures regarding establishing a community support group or advisory board to meet at least once quarterly. The program director indicated in an interview, the advisory board is comprised of local citizens interested in helping the youth and is held quarterly; however, on occasion the meetings could be held more frequent. The advisory board was held on September 2019, December 2019, and January 2020. The program had an advisory board meeting scheduled for April 14, 2020; however, had to be postponed due to the COVID-19. The program maintains sign-in logs and minutes of all who attended the meetings. In order to include involvement from different areas in the community, the program solicits new members through mail to different persons. The program solicited involvement from the local law enforcement, judiciary community, community partners, business community, school board/district, and LGBTQI community. The program solicited involvement from a parent/guardian and former youth. During the annual compliance review, one of the advisory board members were interviewed about the advisory board. The board member, an attorney, reported being on the board for five years and attending three meetings in the last six months. During the meeting, the members discussed community service, items for Christmas and providing gender specific activities.

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 for outlining the program planning process. The program distributes surveys to parents/guardians and youth throughout the youth's stay. The surveys ask questions about safety and concerns regarding the program providing services.

The program reviews annual reports, when completed, during staff meetings in order to make staff aware of the results. The program conducts monthly all staff meeting in order to keep staff informed and provide them the opportunity to provide feedback on several topics. The all staff meetings are held monthly and includes all staff positions, as evident of staff meeting sign-in sheets. Each of the five staff interviewed, confirmed staff meetings are held monthly. The staff indicated during meetings it is discussed program concerns, trainings and concerns related to the youth. Four of the five staff indicated they are not briefed on reports and parent/guardian surveys; one staff indicated being made aware of annual reports. Two of the interviewed staff indicated communication between staff is very good; two indicated good and one indicated fair. Each of the five interviewed staff indicated being able to provide input through meetings and open door policy with administration. The program has taken several initiatives in order to build staff morale and minimize staff turnover. During the all staff meeting, the program holds a cash drawing and the program has employee of the month with a prize. The program recognizes birthdays and staff of the month. The program has a staff morale committee to establish ways to improve staff morale and this information is communicated during all staff meetings. The program director indicated in an interview, completed surveys are reviewed to determine a plan of action to address any issues, concerns or ideas. The annual reports are shared with staff during monthly meetings and/or management 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 outlining how to evaluate staff performance. The program director indicated evaluations are conducted at ninety days, six months, and annually. For each position there is a job description and performance standards, including volunteers. Staff sign and date their specific job description upon hire. Each of the job descriptions can be located in each of the staff personnel records. Each of the job descriptions included all required information and the performance standards are clearly identified and match the performance standard. Of the five staff reviewed, each had an annual performance evaluation completed either in March or April 2020 by the program manager. Each of the evaluations were signed by the staff and program manager. Four of the five interviewed staff, indicated receiving yearly evaluations and one staff indicated receiving monthly evaluations.

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

The program has a policy and procedures to promote activities for youth through recreation and leisure activities. The program has a contract to employ a recreation therapist. The program hired a recreation therapist who has a bachelor's-level degree in sport and exercise science, as well as, experience with youth. The program daily schedule has recreation to be held daily at least one hour a day. A review of the logbooks for the last six months confirmed youth receive large muscle exercise daily. The youth participate in recreation activities such has basketball, football, soccer and dodge ball; and for leisure activities the youth participate in video games, board games and off campus activities. The recreation therapist reported encouraging youth to have input on activities and how to modify activities to their liking. He reported the youth provide feedback verbally and through request forms. Each of the five interviewed youth interviewed indicated participating in one hour of physical activities. Each of the youth indicated participating in various activities such as basketball, football and soccer. Each of the five interviewed staff

indicated youth participated in recreation for an hour a day and participate in basketball, football, and dodge ball.

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 initial contact to parent/guardian within twenty-four hours by telephone and the subsequent written notification of parent/guardian, court, and juvenile probation officer (JPO) within forty-eight hours of admission. A total of five active youth records were reviewed, and all had documentation indicating the appropriate notifications in writing and telephonically were completed within the specified time frames.

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

The program has a policy and procedures in place which addresses youth orientation upon admission. A total of five youth records were reviewed and, in all instances, orientation was conducted on the day of admission. This orientation included available services, the daily schedule, youth expectations, the behavior management system (BMS), medical/mental health services, the Florida Abuse Hotline, the right to be free of and reporting sexual misconduct, contraband, the development of goals and performance planning process, dress code and hygiene, grievance process, emergency procedures, a tour of the program and visitation, phone and mail procedures. Due to the COVID-19 pandemic, there have been no admissions to the program; therefore, an orientation was not observed. The five youth records reviewed had documentation acknowledging receipt of the youth handbook, contraband form, orientation form, and contraband form. The youth handbook contained information on all the above listed topics, which are also discussed in orientation. Five interviewed youth reported they each were given an orientation within twenty-four hours of admission into the program. A review of logbooks reflected the program documented each youth's admission and when the intake was completed. The five youth interviewed all indicated orientation was conducted with their case manager on the date of arrival.

2.03 Written Consent of Youth Eighteen Years or Older	Non-Applicable
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 not had any youth eighteen years of age or older during this review period; therefore, this indicator rates as non-applicable.

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 governing the initial classification process. The five reviewed youth records indicated the initial classification was conducted upon admission. The classification documents identified factors to be used in assignment of living quarters, group or staff advisors. These factors included: the youth's physical characteristics, age, maturity level, any special needs, history of violence, gang affiliation, criminal behavior, and vulnerability to victim and sexual aggression. A new Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) was completed and entered in the Department's Juvenile Justice Information System (JJIS) prior to assigning the youth to a room for each of the five youth. The records also identify any suspected risk factors, such as suicide, medical, escape, and security risks. Youth records containing any of these risk factors are entered in the JJIS as an alert. A review of JJIS verified the appropriate alerts were entered as warranted. Reassessments are completed prior to increasing the youth's privileges, assignment to work projects or any activities involving tools and for any off-campus activities. The program director was interviewed and indicated the program utilizes the VSAB, Massachusetts Youth Screening Instrument-2 (MAYSI-2), and other information, such as mental and physical health status and age when assigning a youth to a room. The program director advised the youth sleep in the common area/dayroom for their first fifteen days prior to being assigned to a room. The program has an internal alert system which is updated daily and can be readily accessed by program staff.

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

The program has a policy and procedures in place detailing the gathering of information regarding youth identified as gang members and the subsequent notification of law enforcement. Two of the five youth records reviewed were applicable for youth identified as gang members and an additional record was obtained and reviewed. Each record confirmed the notification of local law enforcement, as well as the notification of law enforcement in the youth's home jurisdiction. All three case management records documented the local school district and the youth's assigned juvenile probation officer (JPO) as being notified of the youth's admitted gang involvement. A review of the Department's Juvenile Justice Information System (JJIS) confirmed alerts regarding gang involvement were entered as required.

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

The program has a policy and procedures outlining gang prevention and intervention efforts. Two of the five youth records reviewed were applicable for youth identified as gang members and an additional record was obtained and reviewed. The three identified youth records indicated they were participating in gang prevention and intervention groups as required since their arrival at the program. Their performance plans included goals or objectives relating to gang intervention strategies to be completed prior to the youth's release from the program. The program uses the Office of Juvenile Justice and Delinquency Prevention Comprehensive Gang Model, the Phoenix/New Freedom Programming as well as the Brevard Group Treatment Home Juvenile Street Gang lesson plans for gang prevention/awareness instructional classes.

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 regarding the completion of an initial Residential Assessment for Youth (RAY). These assessments are to be completed within thirty days of admission. A total of five youth records were reviewed and, in all cases, the assessment was completed within thirty days of the youth's admission and was maintained in the Department's Juvenile Justice Information System (JJIS). One of the five youth had been in the program over ninety days and required a reassessment. The reassessment was completed within ninety days of the initial assessment. The program maintained all completed assessments and reassessments in the youth's record.

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

A total of five youth records were reviewed and all contained a Youth Needs Assessment Summary (YNAS). These were completed within thirty days of the youth's admission and documented in the Department's Juvenile Justice Information System (JJIS).

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

The program has a policy and procedures which outlines the development and transmittal of performance plans and goals. Five youth records were reviewed, and all contained an Individualized Performance Plan. These were all developed within thirty days of the youth's admission to the program. The Performance Plan Development form was signed by the youth, treatment team leader and pertinent staff participating in the plan and goal development meeting. Each performance plan was developed after the initial assessment. The case manager advised the initial assessments are completed on the date of admission for all youth. There was documentation in all five records indicating a copy of the plan was mailed to the youth's parent/guardian, although none were returned by the parent/guardian with a signature. One of the five youth is under the guardianship of the Department of Children and Families (DCF). The DCF caseworker did not participate in the development; however, the program mailed the plan in order for the caseworker to review and sign. The performance plans all had goals based on each youth's needs, and each addressed the youth's top three criminogenic needs. Each plan included transition activities for the last sixty days of the youth's stay, detailing the responsibilities of the youth and staff as well as target dates for goal completion. Each youth record contained documentation showing a letter and the performance plan were mailed to the committing court, juvenile probation officer, and the parent/guardian within ten working days of the plan being completed. Each of the five interviewed youth indicated they participated in the development of the performance plan and were aware of their goals. The youth also indicated they received a copy of their performance plan and had a good deal of communication with the team as well.

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.	

Five youth records were reviewed for performance plan revisions, but only one youth reviewed had been in the program long enough for a revision to be required. An additional two records of youth having been in the program longer than ninety days were reviewed. Each of these records had a performance plan revision as warranted by the results of the Residential Assessment for Youth (RAY).

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.*	

A total of five records were reviewed for performance summaries, but only one youth had been in the program long enough to require one. Two additional records were reviewed containing performance summaries. Each record contained performance summaries completed at intervals of at least ninety days following the signing of the performance plan. These also contained performance summaries prepared prior to the youth's release. All reviewed summaries contained the status of each performance goal, the youth's progress, academic grades, behavior, and motivation/readiness to change. The three applicable summaries included the youth's interaction with peers and staff, behavior adjustment in the program, and any significant positive or negative events. Each of the three youth are provided an opportunity to read and add comments prior to signing the summary. Copies of the performance summaries were provided to all three youth. The performance summaries were signed by the treatment team leader, staff member preparing the summary, program director, and the youth. The chronological notes in each of the three youth records indicated a copy of the performance summary was sent to the committing court, the juvenile probation officer, and the parent/guardian within ten business days. Three closed records were reviewed for release summaries. Each contained an original signed discharge summary. Two of the discharge summaries were submitted to the youth's juvenile probation officer (JPO), along with the Pre-Release Notification (PRN), at least forty-five days prior to the youth's release. The third was submitted thirty one days prior to planned release. All reviewed records documented the written notification to the parent/guardian once the PRN was approved by the court. A check was conducted of the Department's Juvenile Justice Information System (JJIS) which showed each youth had a Residential Assessment for Youth completed by the program after the PRN was approved. The program does not have any youth applicable for completion of Sexually Violent Predator Program (SVPP).

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

The program has a policy and procedures in place to include parent/guardian's involvement in the treatment process. The program mails correspondence to the parent/guardian upon admission outlining the program and the importance of family being involved throughout this process, to include the assessment process, the development of the performance plan, treatment team meetings, and transition/release planning. Due to the COVID-19 pandemic, the treatment team meetings were attended by phone. A total of seven treatment teams were attended by phone during this review. During the treatment team meetings, the youth's parent/guardian and juvenile probation officer (JPO) were contacted by phone for each meeting. Two of the youth's parent/guardians were not available. An interview with the program director verified the parent/guardians are encouraged to take part in their child's progress by

participating in treatment teams, family meetings/counseling sessions, visitation, family days, and mail. Five interviewed youth reported their parent/guardian is involved in treatment team meetings.

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

The program has a policy and procedures defining the members of treatment team. These include: the youth, team leader administrative representative, living unit representative, treatment staff, educational staff, parent/guardian and others as deemed necessary. Due to the COVID-19 pandemic, the treatment team meetings were attended by phone. A total of seven treatment teams were observed by phone during this review. Observations of these treatment team meetings found staff in attendance included the clinical director, therapists, case manager, transition service manager, the youth; education staff are not at the center at this time due to the COVID-19 pandemic. In one of the treatment team meetings observed, the psychiatrist attended due to the youth taking psychotropic medications. The academic progress is sent to the case manager weekly by the lead teacher. The parent/guardian and JPO were contacted by telephone and participated. Two parents/guardians were not available for the meeting.

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.	

A total of five youth records were reviewed for the incorporation of any other plans into the performance plan. The five youth records had academic plans as well as separate treatment plans incorporated in each youth's performance plan. One youth record indicated the youth was involved with the Department of Children and Families. The youth's treatment plan was incorporated into the performance plan and this was coordinated and communicated with the youth's case worker.

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 bi-weekly treatment team meetings. Rather than alternate formal and informal treatment team meetings bi-weekly, the program conducts formal treatment team meetings bi-weekly. A total of five youth records were reviewed and verified the parent/guardian, juvenile probation officer, and the committing judge were invited to attend treatment team meetings. Formal treatment team meetings were documented in each youth record as being conducted on a bi-weekly basis, except for one youth record which was missing documentation for one meeting. This discrepancy was shared with the program director. All treatment team meeting reports contained the youth's name, date of the review, team members attending and any comments, a synopsis of the youth's progress, plan revisions,

reassessment results if applicable, progress on goals, and positive or negative behavior issues. Due to the COVID-19 pandemic, treatment team members participated telephonically.
A total of seven treatment team meetings were held during the review. The following team members attended each meeting: the clinical director, therapists, case manager, transition service manager, youth, parent/guardian (two were not available), and juvenile probation officer (JPO). Five interviewed youth reported they were given the opportunity during treatment team meetings to demonstrate any skills they have learned in the program. This was also verified during the treatment team meetings, as the youth were all encouraged to participate in the meetings.

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

The program has a policy and procedures in place regarding career education. A total of five active and three closed youth records were reviewed. The indicators surrounding employability skills were non-applicable for four of the youth reviewed, as all but one youth were under the age of fifteen. The program provides Type 2 career education programming and vocational certificates are offered to youth ages fifteen and older. Title 1 Part A provides funding for these certification programs. The certification programs available are Safestaff Food Handling Certification and the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Certification. These certifications are available to youth over the age of fifteen. The lead teacher was interviewed and advised youth are provided with a “My Career Shines” assessment upon arrival, which allows the youth to assess their interests, explore careers, plan for education and prepare for jobs.

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

The program has a schedule for classes, from 7:30 a.m. – 2:40 p.m. (Monday, Tuesday, Wednesday and Friday) and from 7:30 a.m. – 10:40 a.m. (Thursday). This provides a total of twenty-five hours of classroom instruction weekly. The school calendar is spread out over a twelve-month period. Due to the COVID-19 pandemic, on March 16, 2020, the Brevard County School Board restricted all teachers from entering the program, in accordance with the Governor’s restrictions, and instructed teachers to provide five weeks of structured lesson plans. The youth have been split up, with half in a classroom and the other half in the cafeteria following the lesson plan, supervised by program staff, in accordance with the class bell schedule. This schedule was verified during the review. A review of the logbooks, as well as interviews with the youth and lead educator, verified the school schedule is adhered to. Three of the five youth interviewed advised there is a lot of interference during the school day. This information was shared with the program director.

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.	

A total of three closed youth records were reviewed and each included education transition plans with the required individuals involved and notified. Brevard County Public School Board provides guidance regarding the youth's educational needs. Transition plans were developed for the three youth reviewed, with specific plans for continuation of education. The youth were all under the age of fifteen while in the program; therefore, did not have employability as a transition goal.

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

Three closed youth records were reviewed to validate transition planning, conferences and Community Re-Entry Team (CRT) meetings. The three youth records had documentation showing a transition conference was held, although only one had the meeting at least sixty days prior to targeted release date. One transition was held thirty-five days prior to release and the second was held on the day of release. This was discussed with the program director and the program concurred with the findings. In all three cases, the transition conference was attended by the youth, treatment team leader, case manager, education, juvenile probation officer (JPO) and parent/guardian. The JPO and parent/guardian were contacted by telephone. The transition activities on the performance plan were discussed. Community Re-Entry Team (CRT) meetings were conducted for all three youth reviewed, and attended by the youth, case manager, and JPO and a copy of the Outlook invite was maintained in each record. The CRT's were held separate from the transition and exit conferences for each youth.

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 process in completing an exit portfolio for each youth being released from the program. Three closed files were reviewed to ensure the exit portfolio was completed for each youth released. Documentation was in each record verifying the exit portfolio was discussed at the transition conference. During this meeting, the

exit portfolio was discussed, and the portfolio contained the youth's transition plan, a calendar with upcoming appointments listed, birth certificate, and educational records. The exit portfolio was verified at the exit conference for each of the three youth. All three records contained a Receipt of Exit Portfolio form signed by the youth, indicating they received a copy of their exit portfolio, exit conference, and calendar with follow-up appointments.

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

Three closed youth records were reviewed for documentation of an exit conference. Exit conferences were held at least fourteen days prior to each youths' release date and the juvenile probation officer (JPO) was contacted prior to the exit conference. The conference was attended by each youth, treatment team leader, education staff, JPO, and parent/guardian. The JPO and parent/guardian participated telephonically for each of the three exit conferences. The Department's Juvenile Justice Information System (JJIS) was checked and verified the date of admission and date of termination matched for each youth.

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 mental health counselor (LMHC) serving as the designated mental health clinician authority (DMHCA) in the position of the clinical manager. A review of the position description revealed the DMHCA serves full-time. The current DMHCA is a full-time staff on call twenty-four hours a day, seven days a week and responsible for oversight and provision of the mental health and substance abuse services to youth. During the review period, the program had three licensed professionals serving in the position of DMHCA: the current LMHC, a senior director of the program, who is an LMHC, and a licensed marriage and family therapist (LMFT) who is no longer with the agency. An interview with staff revealed the DMHCA is responsible for training and oversight of the mental health/case management professionals within the program. The DMHCA is responsible for providing recommendations regarding types of groups to be implemented within the program and ensuring they are delivered appropriately. The DMHCA is responsible for assisting the director in implementation and fidelity of Standardized Program Evaluation Protocol (SPEP) and evidenced based services. The DMHCA is responsible for providing assessment and consultation regarding mental health crisis or suicide precautions, Baker Act/Marchman Act and managing the Department's Juvenile Justice Information System (JJIS) alert updates related to mental health and substance abuse. In addition, her role is to meet with each youth admitted to the program and provide initial recommendations regarding treatment team assignment, possible areas of concern for treatment, preliminary diagnosis, and referrals/assessments as necessary. The DMHCA is available to assist with clinical services as needed. The clinical manager is available to assist with groups when needed. The clinical manager can provide overlay counseling services in the event a specific youth needs more intensive services or specialized services outside the counselor's expertise.

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 policy and procedures addressing licensed clinical staff. Each of the four licensed mental health professionals providing services hold a clear and active license with the Department of Health, Bureau of Medical Quality Assurance. The program had four licensed clinicians provide services during the review period: two were licensed mental health clinicians (LMHC), one licensed clinical social worker (LCSW), and one licensed marriage and family

therapist (LMFT). Each of the four clinician's license expires March 31, 2021. In addition, there were two psychiatrists who provided direct care services to youth during the review period each of whose license expires January 31, 2022. The program has identified a substitute psychiatrist to provide services in the event of absence. The substitute psychiatrist license expires January 31, 2021.

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 addressing non-licensed clinicians. The program has three non-licensed clinicians currently providing mental health and substance abuse services to youth. One of the non-licensed clinicians is registered with the Department of Health, Bureau of Medical Quality Assurance as a mental health counselor intern (RMHI). The program is licensed under Department of Children and Families (DCF) in accordance with Chapter 397, Florida to provide outpatient treatment substance abuse services expiration date of May 22, 2020. A review of the clinical supervision log for the past twenty-six weeks revealed seven non-licensed clinicians received supervision at some point each week from a licensed mental health counselor (LMHC). The list of clinicians included an additional staff with registration as an RMHI who completed licensure December 19, 2019 but received weekly clinical supervision consistently until then. The supervision log contained documentation in accordance with Chapter 397 and 63N-1 F.A.C. requirements documented on a form containing all required elements. The program has a process for training non-licensed clinicians in conducting the Assessment of Suicide Risk (ASR) as part of the initial training. The program provided documentation of training five non-licensed clinicians in administration of the ASR consisting of co-facilitation with the licensed clinician of five ASRs along with twenty hours of suicide assessment training.

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. Five youth records were reviewed for mental health and substance abuse admission screening. Each record contained a Massachusetts Youth Screening, Version 2 (MAYSI-2) completed by a trained staff upon admission. A records review was documented including a brief clinical interview with the youth completed by the licensed clinician during admission and a review of all elements of the commitment packet. Four of the youth screening instruments signified the need for further assessment and a referral for mental health evaluation was completed. One youth had no indications on the screening instrument, but still received a referral for an evaluation. The program's process included each youth is screened with the MAYSI-2 upon admission, an Assessment of Suicide Risk (ASR) and receives a new mental health and substance abuse evaluation within thirty days regardless of the screening and ASR results. The program director and licensed mental health counselor was documented in each of the five reviewed youth records. The program policy and procedures indicate all staff are trained

in mental health and substance abuse issues and the referral process. There is a standardized process for screening at admission which includes referral for youth who present with emergency mental health or substance abuse issues requiring immediate attention. An interview with administration revealed the process includes at admission or with any change in custody youth are administered a MAYSI-2 and ASR. Each assessment is reviewed by the licensed clinician. Each admitted youth receives a Brief Behavioral Health Status Exam conducted by the licensed clinician.

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 policy and procedures addressing mental health and substance abuse comprehensive evaluations. The program process includes each youth receive a new comprehensive evaluation within thirty days of admission based on screening results and several other assessment instruments. Among the instruments available included Victimization and Vulnerability to Sexual Abuse (VSAB), Assessment of Suicide Risk (ASR), ALL about my Life Assessment, Initial Substance Abuse/Mental Health Treatment Plan, Suicide Ideation Quotient (SIQ), the psychiatric evaluation, Sentence Completion Series, Personal Problem Checklist, Strengths, Needs, Abilities and Preferences (SNAP) assessment, and personal stress management plan. A review of five youth records revealed three youth received a new comprehensive mental health and substance abuse evaluation completed within thirty days of admission by the non-licensed clinician and reviewed by the licensed clinician within ten days. Two of the youth received a new comprehensive mental health and substance abuse evaluation completed within thirty days of admission by the licensed clinician. Both evaluations contained all required elements including the results of the psychiatric evaluation. An interview with the clinical manager revealed the mental health and substance abuse evaluation process included an in-depth review of each youth's commitment packet including the pre-commitment comprehensive evaluation, Community Assessment Tool (CAT) overview report, FACE Sheet and Pre-Disposition Report (PDR) along with the administered Massachusetts Youth Screening, Version 2, ASR, and VSAB assessments. Additional tools include SIQ, All About my Life Assessment, initial substance abuse and mental health treatment plan, face to face clinical interview conducted by the licensed clinician, the psychiatric evaluation, Adolescent Sentence Completion Series, Personal Problem Checklist, SNAP assessment, personal stress management plan, and parent developmental interview. The assigned clinician completes a bio-psychosocial interview and summarizes all data in the comprehensive mental health and substance abuse evaluation.

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 policy and procedures addressing mental health and substance abuse treatment. Each of the five youth records contained an Authorization for Evaluation and Treatment (AET), signed Youth Consent for Substance Abuse Treatment form and a Youth Consent for Release of Substance Abuse Treatment Records form. Each youth record contained a treatment team assignment sheet including the assigned mental health clinician and all other required team members. A review of mental health treatment progress notes revealed each youth was receiving treatment interventions designed to address specific needs identified in his evaluation and treatment plan. Progress notes included all required elements and were reviewed by the licensed clinician. The requirement is for each youth's treatment plan to receive a review every thirty days which would collectively require nine monthly reviews; however, each of the five reviewed records documented a review of the treatment plan bi-weekly in formal treatment team meetings. Five staff were interviewed regarding their facilitation of therapy groups. Four staff indicated direct care staff do not facilitate group therapy. One of the five staff indicated the case manager and program manager facilitate groups along with clinical staff.

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 policy and procedures addressing treatment and discharge planning. Each of the five reviewed records contained an initial treatment plan completed on the day of admission and included all required elements. The initial treatment plan of one applicable youth who was admitted on psychotropic medication included the requirement for an initial psychiatric interview and medication monitoring every thirty days. Each of the five reviewed records contained an individualized mental health and substance abuse treatment plan completed after the evaluation and signed by all required parties. One applicable treatment plan included psychotropic services, medication prescribed, and frequency of medication monitoring. Each plan included the specific frequency of individual, family, and group therapy interventions. Each record documented the initial and individualized treatment plans were mailed to the respective youth's parent/guardian. None of the five youth records contained discharge information. Three applicable closed records were selected for discharge information. Each of the closed records included a mental health and substance abuse discharge plan documented on the required

form. Each reviewed record contained documentation the discharge summary contents were discussed with the youth, parent/guardian, and juvenile probation officer (JPO) at the exit conference. Each record contained documentation a copy of the discharge summary was provided to the youth's parent/guardian and JPO. None of the three reviewed records were applicable for discharge of a youth with an identified suicide risk; however, the program has procedures in place to provide notification to the parent/guardian in case the youth was at risk upon discharge. An interview with the designated mental health clinician authority (DMHCA) revealed the individualized treatment plan is then developed from all information gathered within the comprehensive evaluation. The youth and counselor meet to review problem areas and agree upon objectives and appropriate timeframes based on the youth's strengths, needs and preferences.

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 provides specialized Mental Health Overlay Treatment Services (MHOS). The program provides individual, group, and/or family therapy seven days a week. Group sessions include five days a week of mental health and associated skills group and two days a week substance abuse therapy for applicable youth. Non-applicable youth receive mental health group seven days a week. Each individualized mental health and substance treatment plan included provision of individual counseling twice a month and family therapy once a month. The two youth whose comprehensive evaluation did not indicate substance abuse diagnosis received mental health therapy and skills therapy seven days a week. Youth with co-occurring substance abuse disorders receive substance abuse services. The program has mental health professionals on-site seven days a week and the licensed professional is on-site five days a week. Counselor caseloads do not exceed sixteen youth. The program has a staff psychiatrist who is on-site weekly providing psychiatric services up to four hours. Five youth were interviewed regarding what type of groups or specialized services they were receiving. Three of the youth indicated they were receiving substance abuse treatment. One of the substance abuse applicable youth also indicated he received the Moral Reconation Therapy (MRT) interventions. One of the other two youth indicated he was participating in Impact of Crime and had completed MRT, and one youth indicated he was receiving the Young Men's Work interventions. An interview with designated mental health clinician authority (DMHCA) revealed the program provides MHOS based services in accordance with the contract. As such, the designated mental health clinician authority (DMHCA) ensures a master's-level clinician is on-site seven days a week to provide groups, with a minimum of five mental health groups a week at no more than ten youth in attendance. Additionally, the program provides substance abuse services as treatment plans identify the need with groups two times a week and no more than fifteen youth in attendance. The DMHCA provides training and case consultation regarding MHOS services to the clinicians.

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

The program has policies and procedures addressing provision of psychiatric services. The program receives psychiatric services from a corporate physician who also served during the review period as the designated health authority. The psychiatrist completed a residency in psychiatry and one in child and adolescent psychiatry and is certified in psychiatry by the American Board of Psychiatry and Neurology valid through December 31, 2021. The program provided documentation of a back-up licensed psychiatrist to fill-in during vacations and unplanned absences. The reviewed sign-in documentation revealed the psychiatrist is consistently on-site once a week for up to four hours. Program procedures include each youth receives a referral upon admission for psychiatric evaluation regardless of the youth's previous history. Four of the five youth had no pre-existing psychiatric history. One of the five reviewed records contained documentation the youth was admitted already prescribed with psychotropic medication. The program provided an additional closed record for review. Program staff indicated they had no other applicable youth within the last twelve months. A review of the two applicable records revealed the psychiatrist was notified of the youth's arrival with medication upon admission. The psychiatrist continued the medication and scheduled an initial interview with each youth within seven days. The initial interview was documented on the Clinical Psychotropic Progress Note (CPPN) including page three. One of the youth had an additional psychotropic medication prescribed after admission; the psychiatrist documented the additional medication on page three of the CPPN including calling the youth's parent/guardian, reasons for the additional medication, and symptoms addressed. Each youth prescribed psychotropic medication received psychiatric medication monitoring every thirty days documented on the CPPN including page 3. An interview with the psychiatrist revealed her role is to conduct psychiatric evaluations for all youth, participate in treatment team monthly, and provide medication management for applicable youth. She communicates with the nurses, counselors, clinical managers and director as needed regarding any youth. She stated she is on-site once a week on Thursdays for four hours. She meets with treatment team monthly or as needed. When the program notifies her of a youth referral, he is placed on the list to be seen upon her next site visit which is weekly. She is available for consultation seven days a week, twenty-four hours a day. An interview with administrative staff revealed the clinical manager meets with the psychiatrist weekly to discuss youth receiving psychiatric services. The psychiatrist is on-site for up to four hours a week each Thursday from 10:00 a.m. to 2:00 p.m. Additionally, the psychiatrist participates at a minimum one time a month in treatment team to discuss youth receiving services. The psychiatrist is also available by phone or email twenty-four hours a day, seven days a week to consult with the clinical manager and is able to provide on-site services more frequently as needed.

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 which received an annual review by the program director and designated mental health clinician authority (DMHCA) January 29, 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 a review process.

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

Program procedures include each youth receives an Assessment of Suicide Risk (ASR) at admission regardless of the results of the screening instrument. None of the five reviewed youth were admitted on suicide precautions. A review of five youth records revealed each youth received an initial ASR at admission and were recommended for standard supervision. Staff interviews revealed none of the youth admitted in the review period or in the previous twelve months were admitted with suicide risk indicators and immediately placed on precautionary observation. The program provided two additional applicable youth records for review, one of which documented two occasions requiring the youth to receive a referral for an ASR and recommendation for continued observation on suicide precautions. Each of the three incidents began as the youth disclosed, and staff observed strange behavior. Each of the three received a referral to mental health and was placed on constant supervision. Two of the three incidents, the youth was seen by a licensed mental health clinician the same day and continued on precautionary observation. One of the three incidents the youth was seen by a non-licensed clinician and continued on precautionary observation following consultation with the licensed clinician. The consultation occurred by phone and the ASR was transmitted to the licensed clinician digitally. The licensed clinician signed the ASR the next time she was on the campus. In each of the three occasions, the licensed clinician consulted with the program director and notation was found in the program logbook regarding the youth supervision requirements. Each of the youth were continued on suicide precautions until a follow-up ASR recommended step-down to close supervision. Program procedures require the youth to remain on close supervision until such time recommended by the licensed clinician and documented on the follow-up ASR for step down to standard supervision. A review of the two youth records revealed the program followed procedures in stepping down each youth from close to standard supervision. The program does not use secure observation. The program has two suicide response kits, one in the administration building and one in the dormitory building. A review of the kit revealed it contained all required elements. The program's suicide prevention plan

outlines a review process for every serious suicide attempt or serious self-inflicted injury requiring hospitalization or medical attention. A review team is established to review the circumstances surrounding the event, program 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 any recommendations for changes in policy, training, physical plant, medical, or mental health services, and/or operational procedures. Five staff were interviewed regarding their responsibility if a youth expresses suicidal thoughts. All five staff indicated they would notify mental health and maintain constant sight and sound supervision. Four staff indicated they would document the supervision. Staff were also interviewed regarding the location of the suicide response kit. Five staff identified the location as the dormitory building and four of them also indicated there was one in the administration building.

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.	

Two youth records were applicable for suicide precaution logs. A review of the logs revealed each youth was maintained on suicide observation for the duration of the precautions. At each level of supervision, the youth's behavior was documented in real time. None of the documented observations exceeded thirty minutes. Each of the observations documented warning signs particular to the youth; however, there were no occasions requiring documentation of the identified warning signs. Each log was reviewed and signed by the shift supervisor and mental health clinician. Each log identified safe housing requirements. The applicable youth were not available for interview during the annual compliance review.

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 policy and procedures addressing suicide prevention training. Staff are required to receive six hours annually in suicide prevention training including participation in mock suicide drills. A review of five staff records revealed four of the five received six hours of suicide prevention training, including two hours of on-line and four hours of instructor led training. One staff received five hours of suicide prevention training. A review of mock suicide drills revealed the program conducted drills on each shift at least once a quarter. The team reviewed the last quarter of fiscal year 2018-2019, and the first three quarters of fiscal year 2019-2020. The drills were conducted on April 24, July 25, September 26, October 24, 2019, on all three shifts and on January 31 the first shift and January 23, 2020 the second and third shift. A review of ten staff's involvement in the mock drills revealed each staff participated in a mock suicide drill in at least two quarters in the twelve month period. Each of the drills included the date/time of the drill, time of response, time of contact to 9-1-1, personnel involved, and actions taken. The drill documentation included the outcome of the incident and a critique. Each of the drills utilized the practice of cardiopulmonary resuscitation (CPR) and use of the suicide response kit tools. Each drill was signed by the participants. The program provided documentation of monthly all-staff meetings in which each drill was reviewed for staff who were unable to participate. An interview with administration revealed the program provides trainings

or mock drills during monthly all team staff meetings. Program managers and the nurse conduct certain mock drills every month on all shifts which is listed on the program drill calendar.

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 mental health crisis intervention plan separate from the emergency mental health and substance abuse services plan. The plan included notification, an alert system, means of referral including youth self-referral, communication, supervision, documentation, and review. The plan included the use of the Department's Crisis Assessment form.

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 policy and procedures addressing crisis assessments. The program documented one crisis assessment in the review period. The youth was placed on mental health alert and referred to mental health for an assessment. The crisis assessment instrument contained all required elements including reason for assessment, mental status exam and interview, determination of danger to self and/or others, initial clinical impressions, supervision, treatment and follow-up recommendations and notification to parent/guardian of follow-up treatment. The crisis assessment was completed by a licensed clinician within two hours of referral. Documentation revealed an alert was placed in the Department's Juvenile Justice Information System (JJIS) and the youth was maintained on precautions. The recommendation for the applicable youth was emergency transport for Baker Act and the program followed the emergency mental health services plan of action. The mental health alert observation logs were maintained consistently within the required time frames and included all required supervisory and mental health reviews. The youth was an alleged victim in a Prison Rape Elimination Act (PREA) event and offered mental health treatment services.

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

The program has an emergency mental health and substance abuse services plan separate from the crisis intervention plan in place. The plan included immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services including Baker Act and Marchman Act, documentation, training (including mock drills) and review.

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

The program had three instances of the use of Baker Acts in the review period. Each of the three youth were observed by direct care staff speaking of self-injurious intentions. The direct care staff immediately placed the youth on constant supervision and notified mental health. Each of the three records contained a mental health referral completed by the direct care staff. The licensed clinician completed an Assessment of Suicide Risk in two of the situations and completed a Baker Act and consulted with the program manager who authorized transport to the crisis unit. One of the youth received a crisis assessment completed by the licensed clinician recommending emergency mental health services. She completed the Baker Act documentation and the senior director of the program approved the transport of the youth to the hospital for clearance and then to the crisis unit. All three youth records contained precautionary observation logs consistently filled out every thirty minutes, however, there was no documentation the three youth were placed on one-to-one supervision following the recommendation for emergency transport. Each of the three youth returned to the program from the crisis unit. Upon return, each of the three youth was placed on precautionary observation and a referral made to mental health. Each of the three youth received an ASR within twenty-four hours. Each youth was maintained on precautions until an ASR recommended step down to close supervision.

Standard 4: Health Services

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

The program's written policy and procedures indicated the designated health authority (DHA)/designee is responsible for communication with program staff regarding youth medical needs and having availability for consultation by electronic means twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. The program had a contract with a licensed physician who held a clear and active license, which expired January 31, 2020. This individual met all requirements for independent and unsupervised practice in Florida and acted as the program's DHA until September 2019. In September 2019 the program's DHA changed. The current DHA, since September 2019, has a clear and active license in the State of Florida, expiring January 31, 2022. The DHA's specialty is in adolescent and child psychiatry, as well as adult psychiatry but has demonstrated prior experience in treating the primary healthcare needs of adolescents, as required by the Department's Rule. The program did not have a contract with the DHA, as the DHA was an employee of the program. The DHA designated an advanced practice registered nurse (APRN) who holds a clear and active license to practice in the State of Florida, expiring July 31, 2020, to provide clinical services on-site. The APRN's specialty is in family health. A collaborative practice protocol was in place in which the physician was serving as the facility's DHA and was maintained on-site. The APRN provides clinical services on-site and the DHA performs administrative duties. A review of the last six months of DHA sign-in logs indicated the DHA was on-site weekly as required. Three of the dates, the DHA was on-site, were ten days apart, which is one day over the maximum allowed days between visits. The DHA designated an advanced practice registered nurse (APRN) who holds an active unrestricted license to practice in the State of Florida, expiring July 31, 2020. The APRN's specialty is in family health and a collaborative practice protocol was in place in which the physician was serving as the facility's DHA and was maintained on-site. The APRN provides clinical services on-site and the DHA performs administrative duties. A review of the last six months of DHA sign-in logs indicated the DHA was on-site weekly as required. Three of the dates, the DHA was on-site, were ten days apart, which is one day over the maximum allowed days between visits. The interview with the DHA indicated her role at the program is to oversee the APRN, conduct psychiatric evaluations, participate in monthly treatment teams with all youth on psychotropic medications, and review policies, procedures, and nursing protocols. She indicated she is at the program once a week on Tuesdays from 10:00 a.m. to 2:00 p.m.

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

The program's written policy and procedures outline the program's healthcare services. The designated health authority (DHA) and the facility administrator (FA) sign and date all respective treatment protocols and Facility Operating Procedures (FOP) on an annual basis. The DHA also wrote and approved all treatment protocols and standing orders. The psychiatrist reviewed and signed the FOPs related to psychiatric services. The nursing staff signed and dated a cover page on which all FOPs, and treatment protocols were listed to acknowledge review. The program had one new health care staff since the last annual compliance review and a review of

the registered nurse (RN) comprehensive clinical orientation training indicated it included the Department's health care policies and procedures.

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

A review of five records indicated all had a legible copy of an Authority for Evaluation and Treatment (AET) with the word "COPY" stamped on the AET and maintained in the Individual Healthcare Record (IHCR). In all applicable records the completed parental notifications were kept behind the AET in the IHCR. The nursing staff interview indicated AETs are obtained annually.

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.	

Two of the five records reviewed were applicable for parental notifications; therefore, one more record was requested. In the three applicable records, the parental notifications included significant changes to existing medications, and discontinuation of medication prescribed prior to the youth entering the custody of the Department. In all three, written notifications were sent regardless of telephone notifications, a staff member witnessed the telephone conversations, and this was documented in each record. In two of the three applicable records a psychotropic medication was initially prescribed, discontinued or the drug dosage was significantly changed, and the parent/guardian verbal consent was documented on the Clinical Psychotropic Progress Note (CPPN). The CPPNs were sent to the parent/guardian for signature in both records and were applicable, they were returned with signature. In all of the records reviewed the vaccinations were verified within thirty days of the youth's admission. The nursing staff interview indicated immunization records normally come in with the youth on admission or the nurse can get them from Florida Shots. The records are reviewed upon the youth's admission and as needed.

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.	

In all five records, the Facility Entry Physical Health Screening Form (FEPHS) was completed on the date of admission by the licensed practical nurse (LPN). In one of the five records, the youth had a change in physical custody since arrival to the program. Two more records were requested but the program only had one extra record, which was provided. In the two applicable records the youth received a new FEPHS re-screening upon return to the program which was completed by the LPN.

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's written policy and procedures included the required topics for youth orientation. In all five records, the youth received a general care orientation on the day of admission to the program. The topics included access to medical care, sick call, what constitutes an emergency and when to notify staff, medication process, the right to refuse care and how it is documented. The orientation also comprised of what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the health care providers.

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.	

In two of the five records reviewed, the youth was admitted to the program with a known or suspected chronic condition. One more example was requested from the program. In the three applicable records, a referral was made to the advanced practice registered nurse (APRN) upon admission of the youth and notification was made telephonically. This was documented in each individual health care record (IHCR).

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.	

In all five records, a new Health Related History (HRH) was completed on the youth's day of admission to the program. The HRH was completed by a licensed nurse prior to the Comprehensive Physical Assessment (CPA). In each record, the HRH was reviewed by the advanced practice registered nurse (APRN) and this was documented on the CPA marking a checkbox. The nursing staff interview indicated the nurse is responsible for completing the HRH upon the youth's admission.

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

The program's written policy and procedures are in compliance with the Center for Disease Control (CDC) and Prevention recommendations, the Occupational Safety and Health Administration (OSHA) Standards and included tuberculosis screening. The nursing staff interview indicated the DHA completes a new CPA annually or as needed. In all five records, the advanced practice registered nurse (APRN) completed a new Comprehensive Physical Assessment (CPA) within seven calendar days of admission on the Department form. In all records, the medical grade was documented on the CPA, as well as, all required information pertaining to the rule. All of the CPAs were completely filled out and had sections marked with an "O" or an "X". Any part of the exam which was refused or not completed was appropriately marked and where required the youth signed the refusal on the form. The Department's Problem List was updated when needed and all of the records contained at least one verified

tuberculin skin test (TST) completed within the last year. In all five the youth was assessed prior to placement in general population and the results of the TST were documented on the CPA and the Infectious Communicable Disease (ICD) forms.

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.	

In all five records reviewed the sexually active youth was clinically screened and evaluated for sexually transmitted infections (STI) and in one record the youth was referred to the designated health authority (DHA)/advanced practice registered nurse (APRN) for further evaluation. In all five records, each youth had testing ordered and performed the same day and the referral was documented on the STI form. The testing and screening results, clinical evaluation, and diagnosis were documented on the Infectious Communicable Disease (ICD) form. In all five records, the youth was offered counseling, testing, and treatment for human immunodeficiency virus (HIV); only one youth agreed to testing. In the one applicable record, the consent form was maintained in the Individual Healthcare Record (IHCR), the youth received the testing by a certified HIV counselor, and the HIV test results were filed in a confidential manner consistent with Florida Statute; a sealed envelope was maintained in the IHCR. The program utilizes a separate form to document the pre- and post-test counseling for HIV. The HIV status was not captured in the program's internal alert system. The program has an HIV pre-, post-test counseling and testing provider who maintains a 500/501 certification with the Department of Health (DOH). Five youth interviews indicated they can ask for an HIV test.

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

The program's written policy and procedures, as well as, the contract indicated when there is not a licensed nurse on-site, the program shall have procedures whereby the shift supervisor reviews all sick call requests as soon as possible or at a minimum within four hours after the request is submitted. Furthermore, the contract states sick call care shall be provided on-site at a minimum of four times a week. None of the five records reviewed had a youth present with similar sick call complaint three or more times within a two-week period or complained of any severe pain which staff was unfamiliar. In three of the five records, each youth completed a Sick Call Request form and placed them in a secure location inaccessible to other youth. The licensed nurse practitioner (LPN) completed the Sick Call Request form in accordance with the health services rule and filed it with the progress notes in the Individual Healthcare Record (IHCR) in reverse chronological order. The advanced practice registered nurse (APRN) reviewed the sick call the same day. Each sick call reviewed was documented on the Sick Call Index, as well as the Sick Call Referral Log. The program has posted sick call hours Monday through Friday 7:30 a.m. and 12:00 p.m. and weekends as needed. A licensed nurse conducts sick calls. The review team was unable to observe a sick call during the week of the annual compliance review; no sick call was requested. All five staff interviews indicated the nurse responds and conducts sick call. All five youth interviews indicated they see a nurse within one day of completing a sick call request.

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

The program's written policy and procedures indicated the first aid kits (inclusive of transportation vehicles) are located in designated areas and the designated health authority (DHA) approves the contents. The kits are monitored monthly and replenished as needed. The policy also indicated emergency medical and dental care, including emergency medical services are available twenty-four hours a day. The five interviews indicated all staff are allowed to call 9-1-1 if a youth has a medical emergency. Two of the five records reviewed were applicable on receiving on-site first aid/episodic care. An extra record was requested. In the three applicable records, the youth received episodic care by a licensed nurse, and this was documented in problem-oriented or standard narrative charting, containing all required elements. The episodic care log documented all instances of first aid/emergency care. The program had four first aid kits, one located in the dormitory, one in the hallway of the administration building and two more being used for vehicle transport; those were kept in the staff station room. Three first aid kits were reviewed. All were fully stocked with DHA approved contents. The program had two suicide response kits and two automated external defibrillators (AED); one of each was kept in the dormitory and in the administration building hallway. The AED procedures were located with each AED. Both AEDs were observed, and the nurse performed a self-test indicating they were in working order. The nursing staff conduct a weekly check of each AED to ensure the batteries and pads are operable; this was documented on a checklist and was conducted as required, since the last annual compliance review. The dormitory AED pads expire in February 2021 and the batteries January 2024. The administration building AED pads expire on April 30, 2020 and the batteries June 30, 2024. The nursing staff indicated the AED in the administration building was purchased in 2019. The emergency numbers were posted in the clinic inaccessible to the youth. The program has trained non-healthcare staff in Epinephrine Auto-Injector administration; this requirement was also captured in the program's policy. All five pre-service and five in-service training records indicated all staff received cardiopulmonary resuscitation (CPR), AED and first aid as required. A review of medical drills for the last four quarters indicated the program went above and beyond completing mock emergency drills quarterly and on each shift. The program conducted mock emergency drills which included CPR/AED demonstration as required. A review of the medical drills indicated all staff participated in at least one medical drill in the last four quarters; other than one new staff who did not yet participate in a drill. The staff was hired on February 17, 2020.

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.	

In one of the five records reviewed, the youth required off-site care. Another two records were requested. In two of the three applicable records, the youth required off-site first aid or emergency care and parental notification was made; in the remaining record the youth required off-site care. In all three applicable records, the Summary of Off-Site Care form was utilized and filed in each Individual Healthcare Record (IHCR), as well as the discharge and other documents, where applicable. In all three, the DHA or designee reviewed and signed all off-site care findings, instructions, and information. Two of the three youth required follow-up testing,

referrals, or appointments which were tracked, and each youth received the appropriate care as needed.

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

In two of the five records reviewed, the Facility Entry Physical Health Screening (FEPHS) form indicated the youth was identified as possessing a current chronic condition. One more record was requested. The program indicated they did not have another example for the annual compliance review period. In the two applicable records, the youth was identified as taking prescribed medication on an on-going basis and being classified with medical grade between two and five during admission. Each youth was placed on a chronic illness list and received a periodic evaluation at no more than three-month intervals. Each youth received a specialized treatment plan and the periodic evaluation was being tracked on the medical alert roster. Each periodic evaluation was conducted on-site, documented in the chronological progress note and maintained in each Individual Healthcare Record (IHCR). The treatment orders were written so they were clearly distinguishable for the clinical staff and the Department's Problem List was updated as required. The program director interview indicated the nursing staff have a medical alert roster in place identifying the youth's important medical issues. A medical alert roster is sent out daily to all staff so everyone can be aware of chronic medical issues or updated scheduled appointments. The alerts are discussed in weekly management meetings and are sent by secure email. The designated health authority (DHA) interview indicated every three months or as needed periodic evaluations are conducted for youth with chronic conditions. The DHA designee/advanced practice registered nurse (APRN) perform all periodic evaluations and the evaluation due date is captured on the medical alert roster for review. The DHA will read the youth's progress notes to ensure all periodic evaluations are being conducted.

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.	

The program's written policy and procedures included the disposal of medication. The designated health authority (DHA) or physician designee shall be responsible for verifying the proper destruction and disposal of medications. A licensed health care professional shall be responsible for disposal of medications. Non-controlled medications for disposal shall be inventoried prior to disposal and disposed of in the presence of a witness. The witness shall be a licensed health care professional or facility supervisor or designee. When Reverse Distributor is not utilized for medication disposal, controlled medications shall be disposed of according to the method determined by the facility's interdisciplinary medical team including the consulting pharmacist and registered nurse. All medication disposals shall be documented, and the documentation retained. Quarantined medications shall be destroyed at least monthly. Any non-expired pharmaceutical product subjected to improper storage conditions, contaminated in any way, or deemed to be unusable shall be destroyed. A youth's parent/guardian shall be provided the prescription medications upon the youth's release from the facility. Any medication remaining at the facility for thirty days after the youth's release shall be destroyed. Disposing of supplies will be followed according to the Occupational Safety and Health Administration (OSHA) standards. One of the five youth was taking medications at the time of admission. Two

more examples were requested. The program indicated they only had one more example for youth being admitted with medications. In the two applicable records, the youth was taking medication at the time of admission and the medication was verified prior to being accepted into the program. The prescription verification was documented on the prescription medication verification checklist or the chronological progress notes. In both records, the designated health authority (DHA) and the psychiatrist (same person) were contacted to obtain order to resume the prescribed medications. In the two records, the youth were given medications pursuant to current and valid orders, where applicable the medications were continued, discontinued, changed or a new one was ordered, and the DHA/psychiatrist placed an order on the Practitioner Order form or it was documented in the progress notes. The program utilized the Department's Medication Administration Record (MAR) to document all medication and treatment provided. The MARs clearly indicated start and stop dates of the medications, the staff initialed each administered medication entry and documented at a minimum weekly side effect monitoring on the form. None of the MARs had any lapses or errors and the Six Rights of Medication Delivery/Administration were maintained. The two youth did not refuse any medication administration. All medications were stored in securely locked areas inaccessible to youth. The medication cart was located in the locked staff station room and the remaining stock medications and sharps were in the medical clinic/office. The non-controlled medications and some of the over the counter medications (OTC) were in the locked medication cart. All controlled medications and narcotics were maintained in a smaller silver locked box inside of the medication cart; therefore, being securely stored behind two locks. The medication cart was clean and organized with dividers for the different types of medications. All oral medications are stored separately from topical medications, as well as youth medications being kept divided. The medical clinic has a locked cabinet where the stock OTC medications and sharps are maintained. A separate refrigerator was located in the medical clinic for medications which require refrigeration. A medication pass was observed for two youth. The youth were brought to the administration building for medication pass. The medication cart was placed in the doorway of the hallway and each youth stepped up to the cart separately. The nurse would ask the name, medication the youth was taking, the side effects of the medication, and the dosage of the medication. The medication was verified, placed in a small container and handed to the youth, who took the medication, would cough and open the mouth to show a swipe with the tongue. Four of the five youth interviews indicated they do not take any medication. The one youth stated he received medication administered by the nurse and the process is his name is called, he approaches with a cup of water, gets his medication, drinks the water, swallows and the mouth gets swiped. The nursing staff interview indicated the process for nursing staff to verify a youth's medication regimen when a youth is admitted and the nursing protocol for non-healthcare staff to verify medications upon admission is to call the pharmacy where the medication was filled and to notify the DHA/advanced practice registered nurse (APRN) and verify with the youth's parent/guardian. The nursing staff also states the MAR's utilized at the program had all components of the Department form. The pro-re-nata MARs are preprinted pharmacy MARs and the scheduled MARs are standard Department MARs.

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's written policy and procedures included the disposal of medication. The designated health authority (DHA) or physician designee shall be responsible for verifying the proper destruction and disposal of medications. A licensed health care professional shall be

responsible for disposal of medications. Non-controlled medications for disposal shall be inventoried prior to disposal and disposed of in the presence of a witness. The witness shall be a licensed health care professional or facility supervisor or designee. When Reverse Distributor is not utilized for medication disposal, controlled medications shall be disposed of according to the method determined by the facility's interdisciplinary medical team including the consulting pharmacist and registered nurse. All medication disposals shall be documented, and the documentation retained. Any non-expired pharmaceutical product subjected to improper storage conditions, contaminated in any way, or deemed to be unusable shall be destroyed. A youth's parent/guardian shall be provided the prescription medications upon the youth's release from the facility. Any medication remaining at the facility for thirty days after the youth's release shall be destroyed. Disposing of supplies will be followed according to the Occupational Safety and Health Administration (OSHA) standards. The policy also included the medication error/lost items reporting guidelines. All medications were stored in securely locked areas inaccessible to youth. The medication cart was located in the locked staff station room and the remaining stock medications and sharps were in the medical clinic/office. The non-controlled medications and some of the over the counter medications (OTC) were in the locked medication cart. All controlled medications and narcotics were maintained in a smaller silver locked box inside of the medication cart; therefore, being securely stored behind two locks. The medication cart was clean and organized with dividers for the different types of medications. All oral medications are stored separately from topical medications, as well as youth medications being kept divided. The medical clinic has a locked cabinet where the stock OTC medications and sharps are maintained. A separate refrigerator was located in the medical clinic for medications which require refrigeration.

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

The program has infection control procedures including prevention, containment, treatment, and reporting requirements related to infectious diseases, as per the Occupational Safety and Health Administration (OSHA) federal regulations and the Center for Disease Control (CDC) guidelines. The infection control procedures included common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infection diseases, tuberculosis, hepatitis A, B and C and human immunodeficiency virus (HIV) infectious diseases caused by blood-borne pathogens. The plan also encompassed other outbreaks of epidemics caused by any other infectious agent (COVID-19), outbreak of pediculosis and/or scabies, methicillin-resistant staphylococcus aureus (MRSA) and other emerging antibiotic-resistant micro-organisms, food-borne illnesses, and bio-terrorist agents. The infection control procedures discussed chemical exposures in the workplace, hepatitis B immunizations, personal protective equipment (PPE) and standard universal precautions which need to be followed by all staff. The program has a comprehensive process for needle stick post-exposure evaluation contained in the infection/exposure control procedures. The exposure control plan was written in accordance with the OSHA standards and was reviewed and signed by the administration of the program in March 2020. The plan included risk assessment and methods of compliance. The program had one instance were the local health department had to be notified due to a client with a sexually

transmitted disease. There were no other instances in which the local county health department, CDC, or the Central Communications Center (CCC) had to be contacted due to infectious diseases, quarantining or hospitalization of staff or clients. The program director interview indicated one exposure control plan is located in a binder in the staff station on the medical cart and one is located in nurse's station/office. The plan is reviewed with staff in the monthly staff meetings.

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

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

Standard 5: Safety and Security

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

A review of the program's policy and procedures verified the program adheres to their policy when providing supervision to the youth. The review team observed staff supervision of youth during class, meal time, recreation and transition from one area to another. At no time was the program out of compliance with their staff to youth ratio. The program's daily schedule was reviewed and through observation of the supervision while on-site during the annual compliance review, it was validated the program adhered to their schedule. The schedule documented activities such as hygiene, meals, groups, education, recreation, sick call and treatment teams. The schedule is posted on the dormitory and throughout the program. Youth were involved in a full schedule of activities while the review team was on-site. Staff and youth interactions were positive and consistent with the program's behavior management system. Five staff were interviewed and indicated if there is a discrepancy in the count, all movement stops and an emergency count is conducted.

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 regarding their behavior management system (BMS). The BMS is clearly written and is posted in the dormitory and in the youth handbook, which all youth receive upon admission and sign acknowledging receipt. A review of five open youth records validated each youth signed for the program's youth handbook upon their admission. The rules regarding the BMS, including the positive and negative consequences for behaviors are listed in the youth handbook. The program's BMS has not changed since the last annual compliance review and included all required elements. The program's BMS addresses a ratio of five-to-one positive to negative consequences. The negative consequences are in direct relation to the seriousness of inappropriate behavior exhibited and examples are listed in the youth handbook, as well as a variety of rewards and incentives. The program and the school personnel have a signed contract regarding the implementation of the joint BMS during school hours. Five staff were interviewed and each were able to explain the program's BMS; and each indicated youth items/personal belongings cannot be taken from the youth as a consequence. The staff were able to explain incentives the youth receive as part of the BMS. Five youth were interviewed and each was able to explain the difference between each level and how youth move from level to level. The youth were able to explain the consequences received for negative behaviors and indicated they are given verbal warning, then staff talk with youth to allow them to calm down, then youth are able to take a time out to cool off if need be and staff

can take away privileges if necessary; three youth indicated room confinement is utilized. These three youth were interviewed again to explain room confinement. At the time of re-interviewing the three youth, it was clearer the youth were referring to either separating the youth if a fight should take place or the youth may be separated from the other youth to cool down; at no time is a door shut if they go to their room. None of the three youth had ever experienced being in their room for punishment, nor had they witnessed this. Each youth also indicated they may have been confused by the question. The program director was interviewed and was able to explain the program's BMS and able to explain the incentives and rewards the youth are able to earn. He further indicated he monitors all youth consequences; when a youth is placed on a problem behavior report (PBR), the youth are able to discuss and explain their behavior. He also stated the PBR has selected consequences for the infraction and this is how the consequence is determined for consistent practice.

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's policy and procedures indicated staff will receive feedback during all staff meetings and on their annual evaluations. A review of the case manager, clinical manager, behavioral health technician, behavioral therapist, program manager, senior program manager, and senior case manager's position description validated the expected qualifications for the BMS are included in each. The program's BMS allows for youth to explain their behavior and the sanctions are explained to the youth upon implementation. The program's BMS does not include increased length of stay, denial of youth's basic rights, promotion of group punishment, punishment of youth by other youth, nor disciplinary confinement. Five staff in-service and pre-service training records were reviewed and validated all received training on the program's BMS. On two occasions, in the last six months, education staff and program staff were trained jointly on the combined BMS plan to include use of BMS during school. The program director was interviewed and indicated staff performance evaluation's address the program's BMS and this is how staff are monitored to ensure consistent practice of the BMS; however, the program director imposes all behavior related consequences to allow for consistent practice. Five youth were interviewed and indicated youth are never permitted to punish other youth. The five youth were able to provide multiple examples of incentives and rewards provided by the program. All five youth further indicated staff provide rewards and incentives in a consistent manner. When asked how they would rate the BMS, four indicated very good and one indicated good. Five staff were interviewed and asked how and where youth are able to explain their behaviors and where youth are explained their consequence. Each staff explained the program has a "pink sheet" which is the program's Problem Behavior Report. On this report there is a section explaining the behavior and a section for the youth to notate their response to the incident. Staff were also asked how leadership provides feedback on the implementation of the BMS and staff explained management provides effective feedback and is provided during shift briefing or when staff are implementing the BMS.

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

The program has thirty-four cameras and all are operational and each store thirty days of video recordings. The program was working two shifts 6:00 a.m. to 6:00 p.m. and 6:00 p.m. to 6:00 a.m. at the time of the annual compliance review and a few weeks prior. An observation of three days during the 6:00 p.m. to 6:00 a.m. shift, two hours each shift, for a total of six samples, validated ten-minute checks were completed as required and within the ten-minute timeframe. The ten-minute check sheets were compared to video recording for each of the three days. All three compared and matched with no ten-minute checks missed or completed late. The ten-minute check sheets noted actual time with staff initials. Five staff were interviewed and indicated room checks are completed every ten minutes when youth are placed in their room for sleeping or non-punishment reasons.

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.*	

A review of the program's policy and procedures validated the program must conduct counts at the beginning of the shift, after outdoor activities and during any emergency situations. A review of the program logbooks validated the program follows their policy and procedures as well as conducts counts every thirty minutes. An observation of counts was conducted during the annual compliance review and those counts were documented in the program's logbook. Program staff also document when staff are away from the program and document each count. Five staff were interviewed and three indicated youth counts are conducted randomly throughout the day and two staff indicated counts are conducted every thirty minutes. Staff further indicated if there is a discrepancy in the count, all movement stops and an emergency count is conducted.

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

A review of the program's logbooks validated all logbooks are bound with numbered pages; all entries are made in ink with no erasures or white-out; no logbook entries were obliterated or removed; all errors were struck through with a single line and dated and initialed by the staff correcting the error. Each logbook page was dated and each entry noted a brief description, included the staff and youth involved and was signed by the staff noting the entry. The program also utilizes daily shift reports, which documents daily program information. The program supervisor briefs incoming staff regarding the contents of the shift report. All incoming staff sign and date the shift report for the previous shift and also sign the logbook acknowledging review of the logbook. Each reviewed logbook, during the annual compliance review, documented all required events, incidents, and activities at the program. All calls to the Central Communications Center and Florida Abuse Hotline were noted in the program's logbook.

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*	

A review the program's policy and procedures, and review of the program's process, validated the program adheres to their policy and procedures. The program does not have a master control; therefore, the program has a system where they maintain a locked coded box which contains a key to the secure key box. The supervisors have access to the coded lock box and are able to access the key box to retrieve staff keys when the administration assistant is not on-site. The key storage area is secure in the administration hallway, which is behind a locked door. The key storage area was secure and this validated through observation during the annual compliance review. Distribution of keys was observed during the annual compliance review week and it was determined the program adheres to their policy and procedures. A review of three staff member's key rings validated they matched the program's key inventory. The key inventory documented permanent assigned keys, active keys, restricted keys and authorized keys, as well as keys which are assigned each day on each shift. There is only one set of keys assigned to the shift supervisor on each shift, in addition to staff who have permanent issued keys. Each staff who are assigned permanent issued keys must sign a form acknowledging they received the keys. The program director completes an inventory and tracking of keys each month, which was observed during the annual compliance review. The program's policy and procedures address keys which are lost, missing, or damaged. Daily tracking of keys is documented on the daily shift report. No keys have been lost or missing since the last annual compliance review. The program director indicated, during an interview, only medical keys are issued to medical staff, mental health keys are issued to mental health staff and only case management keys are issued to case management staff. Five staff were interviewed and all

were able to explain the key control process, including key assignment and the process for missing and damaged keys.

5.08 Contraband Procedure	Satisfactory Compliance
The program's policy must address illegal contraband and prohibited items. *A program shall delineate items and materials considered contraband when found in the possession of youth, the list must include: sharps, escape paraphernalia, tobacco products, electronic or vaporless cigarettes, non-facility issued electronic equipment or devices, metals, personal non-facility issued cellular devices, unauthorized currency or coin(s), and non-facility issued keys. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its staff/youth.* *The program shall document the confiscation of any illegal contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the program director or designee has the discretion to discard the item, return it to its original owner, mail it to the youth's home, or return it to the youth upon release. In all instances involving confiscation of illegal contraband, the program shall turn the item over to local law enforcement and a criminal report filed.*	

The program's policy and procedures ensure the system in place prevents contraband from entering the program. The policy and procedures indicated law enforcement shall be contacted if any contraband is found and considered illegal and included the contraband guidelines. The P&P did not contain information regarding staff being found in possession of contraband and the consequences to follow; however, the staff handbook, which the staff sign for upon hire, does list the items and materials considered contraband and the consequences of possessing contraband. The program updated their policy and procedures to include this information while the review team was onsite. The program defines items and materials considered contraband, which is located in the program staff handbook, youth handbook, and the policy and procedures. The list of contraband items included all required items considered contraband. The youth handbook contains the consequences for youth if found with contraband. A review of the program's shift reports validates searches of the physical plant, program grounds, and youth are conducted. The program documents confiscation of contraband on the programs room search sheet, which is randomly conducted on a bi-weekly basis. If items are not considered illegal, they are returned to the proper area or discarded. There were no contraband items considered illegal, found since the last annual compliance review and no Central Communications Center reports completed. A review of the program's shift reports validated facility searches are conducted daily. The program director was interviewed and indicated in the event contraband is discovered and is not of illegal nature, he will choose to discard the item, send the item home or return it to the youth upon release from the program. In the event the contraband is discovered to be of legal nature, the director will turn it over to local law enforcement.

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.	

During the annual compliance review week, an observation of searches of youth before and after groups, education, meals and recreation were completed. During the annual compliance review week there were no transports, visitation, admissions, or off-campus activities. There are no Class A tools on-site; therefore, there were no observations of youth use of tools. An observation of youth searches validates the staff search the youth in a manner to ensure the youth are treated with respect and dignity and each search was conducted in a thorough manner. Each youth was searched by a male staff member and the search was conducted according to the PAR training manual. Five staff were interviewed and indicated youth searches are conducted after every transition from one area to another. Three staff also indicated room searches are completed weekly. Five youth were asked when youth searches are conducted and each indicated after returning from off campus, after outdoor activities, when items are missing, after visitation, and after meals.

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

The program has two facility vans used to transport youth in the program. A review of program vehicle invoices from the automotive shops validated the annual inspections were completed on each van; one completed on June 20, 2019 and the other completed on June 24, 2019. There were also additional invoices for the program vehicles indicating the vehicles are mechanically maintained. There were no transports during the annual compliance review. An interview was conducted randomly of staff and youth who indicated youth are never left alone in the vehicles, never permitted to drive and youth always wear a seatbelt. The program director also indicated two staff accompany a transport when there is only one youth being transported. A random check of personal and facility vehicles validated all were locked. One facility vehicle was in the shop and not on-site during the annual compliance review week. The other vehicle was observed and contained a fire extinguisher and appropriate number of working seatbelts. The keys are located in a lock box inside the administration office, where the seatbelt cutter and window punch are attached to the key ring. The two first-aid kits, for the two facility vehicles, are also maintained in the vehicle key lock box. Youth are not attached to the vehicles during transport and the safety screen is not applicable for this program, as it is not a high-risk or maximum-risk program.

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 regarding transportation of youth. A review of the program's process validates the program adheres to their policy and procedures. There were no transports during the annual compliance review week; therefore, three randomly selected staff were asked what the staff to youth ratio is when transporting youth to which they all indicated one to five except when transporting to court or a doctor's appointment, at which time the ratio is two staff for any transport. Their policy and procedures indicate two staff will always transport youth when conducting a transport to court or medical appointments or when a youth is high risk. Their policy and procedures indicate the staff to youth ratio is one to five when conducting a transport for leisure activities and recreational activities. The program maintains a list of staff who are permitted to conduct transports of youth. The program's policy documented the program verifies staff have a current driver's license on a quarterly basis; however, upon further review the program indicated their corporate office verifies staff have a current driver's license and their corporate policy indicates this is completed on an annual basis. As a result, the program updated their policy, while the annual compliance review team was onsite, to reflect their corporate policy. A random check of personal and facility vehicles was conducted while the review team were on-site, and no vehicles were unsecure. A safety screen in the facility vehicles is not applicable for this program, as it is not a high-risk or maximum-risk program. According to the program policy and procedures, all youth and staff are to wear a seat belt during any transport and a youth is never left unattended in a vehicle. Five staff were interviewed and indicated they are never permitted to transport youth in their personal vehicle. Four staff indicated they are provided a cell phone when transporting youth; one staff indicated they were not sure if a cell phone was provided when transporting a youth, as he had not completed a transport.

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 regarding Weekly Safety and Security Audits, which indicates the program director is responsible for conducting the weekly audits; corrective actions will be completed as a result of any deficiencies; and there is an internal system to ensure the deficiencies are corrected. The program's policy and procedures met the requirements of the Department's Rule. A review of Weekly Safety and Security Audits for the last six months validated audits were conducted each week; however, eight weekly audits were late; five were one day late, one was two days late, and two were four days late. The program director was interviewed and indicated a daily facility walk through is conducted to look for any deficiencies, if a deficiency is detected a work order is submitted to the Aspire Engineer team to fix or repair deficiencies. In addition, all deficiencies are discussed in weekly management meetings or brought to his attention immediately when an issue is noted. The program director further indicated, the weekly Safety and Security Audits are conducted to document and report any deficiencies; if deficiencies are noted a work order is submitted.

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

The program has a policy and procedures regarding tool inventory and management which address the issuance, inventory and control of equipment and tools. The policy indicated there are no Class A tools on-site; therefore, they do not maintain an inventory of Class A tools. Through observation of the facility and the storage area, it was validated there were no Class A tools on-site. The program only maintains Class B tools, to include brooms, mops, push broom, scrub brushes, dust pans, and mop buckets. The program director conducts an inventory of all Class B tools, at a minimum of monthly, but often times two to three times a month, which was observed by the annual compliance review team while on-site; in addition to a daily inventory which is documented on the daily shift report and is conducted by floor staff. If any Class B tools are dysfunctional or damaged, the program director is notified and the tools are disposed of offsite. All kitchen utensils are located on a shadow board and consist of whisks, ladles, spoons, tongs, measuring cups, and pastry brushes. The kitchen utensils are behind two locked doors. The facility has no knives on-site; all food is pre-cut. A review of the kitchen utensil inventory validated it was conducted a minimum of monthly as required, but often times is conducted on a weekly basis. A review of training documentation validated all staff and all youth are trained on the intended and safe use of tools. Staff were trained on September 25, 2019 and youth were trained on February 20, 2020. Five staff were interviewed and indicated youth are only permitted to use brooms, scrub brushes and mops.

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's policy and procedures regarding youth tool handling and supervision is specific to any special projects utilizing Class A tools, in the event Class A tools are brought on-site for a project. All youth receive a risk assessment on a monthly basis. The risk assessment would be utilized to determine the youth's risk level when being assigned to a project; the staff to youth ratio is one to five. The policy and procedures indicate all youth are searched and all tools are accounted for prior to and immediately after a work project. A work project did not take place during the annual compliance review week; however, a review of five youth records validated each youth received a risk assessment each month since admission to the program. Five youth were asked what tools they are permitted to utilize and four indicated mops, brooms and scrub brushes; one youth indicated they are not permitted to use any tools.

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

The program's policy and procedures address outside contractors and the process to follow when outside contractors are onsite. A review of three invoices, the program's External Vendor Security Agreement forms, and sign-in sheets validated all three outside contractors followed the program's policy and procedures. The program's policy and procedures address the check in and check out process of all tools, tool restrictions limiting only necessary tools on-site, youth restrictions in work area noting no youth should be in the work area at any time, and to notify the

program director immediately in the event a tool is missing. The program's policy and procedures did not address who is responsible for providing approval of items such as cellular phones or electronic devises and allowing the contractor to bring such items onsite. As a result, this was addressed with the program director, who updated the program's policy and procedures while the annual compliance review team was on-site.

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.	

A copy of the program's Continuity of Operations Plan (COOP) was reviewed, which documented fire drills are to be conducted monthly and one COOP drill shall be conducted annually. A review of supporting documentation of COOP drills and fire drills for the last six months validated the program conducted a fire drill each month on each of the three shifts. A COOP drill was conducted each month except for one during first shift, and one for each month except for two during second shift and third shifts, far exceeding their COOP requirement. Fire evacuation routes and egress plans were posted throughout the facility, including the dorm, administration, classrooms, the dining hall and kitchen. The program maintains ten fire extinguishers, of which all were inspected January 2020. The program director was interviewed and indicated drills are conducted monthly; the program has a twelve-month schedule with selected drills to be conducted each month. He further indicated the operational drills conducted are in the area of fire, escape, bomb threat, work place violence, active shooter, chemical spill, power failure, hurricane, hostage and Prison Rape Elimination Act (PREA). The medical drills conducted are in the area of suicide attempt with hanging and use of knife-for-life, heat exposure, head injury, chocking, loss of conscious, asthma, low/high blood sugar, burns, fracture/sprain, cuts and chest pains. Five youth were interviewed and each indicated they have been instructed what to do in case of a fire. Four indicated they participate in a fire drill two times a month, while one indicated they participate one time a month. Five staff were interviewed and indicated they have participated in the following drills within the last six months, weather, disturbance, bomb threat, hostage situation, escape, fire, mental health, and medical.

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's Continuity of Operations Plan (COOP) is located in the program director's office, on the youth dormitory and is accessible to staff for review at any time. The program's disaster plan is part of the program's COOP, which addresses in detail alternative housing plans. The COOP was submitted to the Department for review on March 27, 2020 and was signed and approved on April 3, 2020. The program provided an invoice documenting an order for freeze dried long term food supply for the upcoming hurricane season; however, the supply is on back order with estimated date of arrival March 20, 2020. The program did not have any perishable

food on site for an emergency; however, had daily perishable food. In addition, the program has a large supply of bottled water with a note indicating it is for hurricane season and not to be consumed. The program director was interviewed and indicated the COOP Plan is located on the dormitory in the staff station and in the administration area. He further stated the COOP Plan is always available for staff to review. The COOP contains all required information and the annexes are updated annually. The program maintains a folder for each active youth, which is located in a filing cabinet in the front administration office. The folder contains all required critical identifying information for each youth to be utilized in the event of an emergency.

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

The program's policy and procedures regarding the storage and inventory of flammable, poisonous, and toxic items and materials indicate no youth shall be permitted to directly handle any such items. The program only maintains cleaning products on-site, to include hand soap, Ajax cleaner, disinfectant spray, glass cleaner, and laundry detergent. The program maintains a Safety Data Sheet for each of these items, which is documented in each area these items are located. An inventory is maintained for each of these items and is maintained weekly by the program director and daily, after each use, on the daily shift report. A review of the inventory, all cleaning chemicals and observation of the storage shed validated all chemicals were accounted for. All staff are permitted to handle and use all of the cleaning chemicals onsite. The storage shed is accessible to administration staff and shift supervisors and is inaccessible to all youth.

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's policy and procedures regarding the storage and inventory of flammable, poisonous, and toxic items and materials indicates no youth shall be permitted to directly handle any such items. According to the program's policy and procedures, no youth are permitted in the area of an outside contractor in the event they have such items on-site. It further states no youth will handle, clean or dispose of any person's bio-hazardous material, bodily fluids, or human waste. No youth has access to the storage area or any area where cleaning supplies are stored. Youth assist with cleaning in the evening, where the staff handle the cleaning supplies and the youth are able to scrub or mop to assist in the cleaning; this was not able to be observed during the annual compliance review. A review of the program's Preventive Maintenance Checklist

validates it is completed weekly and in accordance with the Department's Rule. Five youth were interviewed and indicated they do not have access to or handle any flammable, poisonous, and toxic items and Materials. All five indicated staff sprays the cleaning product and the youth wipes down the surface.

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's policy and procedures indicate the program director will be responsible for the disposal of all flammable, toxic, caustic, and poisonous items in accordance with Occupational Safety & Health Administration (OSHA) Standards. A review of the program's Class B tools, flammable, toxic, caustic, and poisonous items disposal forms, for the last six months validates the program director disposes of all empty cleaning supply containers offsite. Through an interview with the program director it was determined he has not received training in the disposal of flammable, toxic, caustic, and poisonous items and indicated this is because there are no such items onsite. The kitchen grease is disposed of and retrieved by an outside company. A review of the disposal form and invoice from the most recent grease disposal, validates this practice. The program does not utilize hazardous liquids. The program director indicated since they do not have chemicals onsite which would require a hazardous chemical spill policy the program did not have it included in their policy and procedures; however, after further discussion, the program director added this to their policy and procedures in the event an outside contractor brings such items on site. The program director was interviewed and indicated the program does not have toxic, caustic or poisonous items on the facility grounds. Any cleaning container is turned into the program manager where disposal of the canister is disposed of off campus and documented on the program's disposal sheet.

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's policy and procedures indicate visitation is on Sundays from 2:00 p.m. to 4:00 p.m. It also states the case manager will ensure bi-weekly phone contact with each youth's parent/guardian. However, the youth handbook indicates youth will receive one phone call a week and each youth is assigned a day to make their weekly phone call. A review of the telephone log validates youth are able to have telephone contact with their family members each week. The parent/guardian is also encouraged to participate in the formal monthly treatment team meetings. A pre-approved client information list is created for each youth verifying who the youth are permitted to have contact with while admitted in the program. The visitation schedule is posted on the youth dormitory. A review of the sign-in sheet for visitation validates visitation takes place on Sunday's from 2:00 p.m. to 4:00 p.m. A review of the mail correspondence list validates youth send and receive mail. According to the program's policy and procedures all incoming and all outgoing mail is searched by the program managers or the

program director. The program's policy states if families are not able to make visitation, a special family counseling will be attempted, even by phone if need be in order for youth to have visitation. Five youth were interviewed and each indicated they are provided with the opportunity to communicate with their families through mail, telephone and visitation.

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

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

5.24 Controlled Observation	Satisfactory Compliance
Programs shall only place youth in Controlled Observation when non-physical interventions would not be effective.	

The program's policy, procedures, 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	Satisfactory Compliance
The program shall conduct safety checks for youth on Controlled Observation. The program director or designee shall approve a release when it is determined, based on his or her behavior, the youth is no longer an imminent threat to self or others.	

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

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

A review of five youth safety plans validate each youth's safety plan was developed within the required fourteen days; all five safety plans were created on the youth's admission date. Safety plans are not provided to the staff; however, each youth's information regarding safety plan details are located in the alert binder for all staff to review. Of the five youth safety plans reviewed only one documented family/parental input. Of the five safety plans, two plans contain an area on the plan to document family/parental input; however, the other three forms did not. The clinical director indicated the form was updated in January to reflect family/parental input. Of the two forms which did contain an area on the form to notate family/parental input, there was only one which did. Of the five safety plans, none documented where recommendations from previous or current clinical assessments or screening instruments and trauma responsive practices were incorporated into the plans. Clinical staff do not update the youth safety plans every thirty days; however, they do address and review each youth's safety plan every two weeks during the youth's treatment team meeting. If at this time the safety plan is in need of an update, it is updated. Clinical staff provide floor staff with a list of positive and negative behaviors, triggers, and coping strategies and ask the staff to complete the form for each youth

and submit back to clinical staff to be incorporated into the decision to update the safety plan. Five staff were interviewed and two indicated safety plans are kept in the alert binder, two indicated on the dormitory and one indicated in the youth records. The five staff indicated a different answer when asked where youth safety plans are kept; one indicated they are in the internal alert form; one indicated they are in a binder, one indicated they are kept in a youth file, in a binder in the dormitories, and the other staff indicated they are located in the dormitory in a safety kit and some are in administration. Five youth interviews indicate they participated in the development of their safety plan.