STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

Brevard Group Treatment Home

Aspire Health Partners

(Contract Provider)

3905 Grissom Parkway

Cocoa, Florida 32926

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

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Kamille Payne, Office of Program Accountability, Lead Reviewer (Standard 1)
Tony Altman, AMIkids Inc., Executive Director (Standard 5)
Teresa Andersen, Office of Program Accountability, Deputy Supervisor (Interviews)
Nicos Antonakos, Office of Program Accountability, Technical Assistance Specialist (Standard 1 & SPEP)
Paul Czigan, Office of Program Accountability, Regional Monitor (Standard 5)
Cindy Jones, Office of Education, Deputy Director of Education (Standard 2)
Jillian Lewandowski, Office of Program Accountability, Regional Monitor (Standard 2)
Tamara Mahl-Adkins, Office of Program Accountability, Regional Monitor (Standard 4)
Bonita Williams, Office of Program Accountability, Regional Monitor (Standard 3)

Program Name: Brevard Group Treatment Home
Provider Name: Aspire Health Partners
Location: Brevard County / Circuit 18
Review Date(s): February 5-8, 2019

MQI Program Code: 571
Contract Number: R2109
Number of Beds: 30
Lead Reviewer Code: 161

Methodology

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

Persons Interviewed

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

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

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

Documents Reviewed

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

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

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

Observations During Review

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

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

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

Comments

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	* Initial Background Screening	Failed
1.02	Five-Year Rescreening	Failed
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	Limited
1.07	* Pre-Service/Certification Requirements	Satisfactory
1.08	In-Service Training	Limited
1.09	Grievance Process	Satisfactory
1.10	Delinquency Intervention and Facilitator Training	Satisfactory
1.11	Life Skills Training Provided to Youth	Satisfactory
1.12	Restorative Justice Awareness for Youth	Satisfactory
1.13	Gender-Specific Programming	Satisfactory
1.14	*Internal Alerts System and Alerts (JJIS)	Satisfactory
1.15	Youth Records (Healthcare and Management)	Satisfactory
1.16	Youth Input	Satisfactory
1.17	Advisory Board	Satisfactory
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

Standard 2 - Assessment and Performance Plan		
2.01	Initial Contacts to Parent/Gaurdian and Court Notification	Satisfactory
2.02	Youth Orientation	Satisfactory
2.03	Written Consent of Youth Eighteen or Older	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	R-PACT Assessment and Reassessments	Satisfactory
2.08	Youth Needs Assessment Summary	Satisfactory
2.09	*Performance Plan Development, Goals and Transmittal	Satisfactory
2.10	Performance Plan Revisions	Satisfactory
2.11	Performance Summaries and Transmittals	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	Limited
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	Satisfactory
4.05	Notification - Clinical Psychotropic Progress Note	Satisfactory
4.06	Immunizations	Satisfactory
4.07	Healthcare Admission Screening Form	Satisfactory
4.08	Medical Alerts	Satisfactory
4.09	Youth Orientation to Healthcare Services	Satisfactory
4.10	Designated Health Authority/Designee Admission Notification	Satisfactory
4.11	Healthcare Admission Rescreening	Satisfactory
4.12	Health Related History	Satisfactory
4.13	Comprehensive Physical Assessment	Satisfactory
4.14	Female-Specific Screening/Examination	Non-Applicable
4.15	Tuberculosis Screening	Satisfactory
4.16	Sexually Transmitted Infection Screening	Satisfactory
4.17	HIV Testing	Satisfactory
4.18	Sick Call Process - Requests/Complaints	Satisfactory
4.19	Sick Call Process - Visits/Encounters	Satisfactory
4.20	Restricted Housing	Non-Applicable
4.21	Episodic/First Aid Care	Satisfactory
4.22	Emergency Care	Satisfactory
4.23	Off-Site Care/Referrals	Satisfactory
4.24	Chronic Illness/Periodic Evaluations	Satisfactory
4.25	Medication Management - Verification	Satisfactory
4.26	Medication Management - Orders/Prescriptions	Satisfactory
4.27	Medication Management - Storage	Satisfactory
4.28	Medication Management - Medication and Sharps Inventory	Satisfactory
4.29	Medication Management - Controlled Medications	Satisfactory
4.30	Medication Management - Medication Administration Record	Satisfactory
4.31	Medication Management - Medication Administration By Licensed Staff	Satisfactory
4.32	Medication Management - Medication Provided By Non-Licensed Staff	Satisfactory
4.33	Medication Management - Psychotropic Medication Monitoring	Satisfactory
4.34	Infection Control - Surveillance, Screening, and Management	Satisfactory
4.35	Infection Control - Education	Satisfactory
4.36	Infection Control - Exposure Control Plan	Satisfactory
4.37	Prenatal Care - Physical Care of Pregnant Youth	Non-Applicable
4.38	Prenatal and Neonatal Care - Nutrition, Education of Youth, and Lactation	Non-Applicable
4.39	Prenatal and Neonatal Staff 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	Limited
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	Failed
5.05	Census, Counts, and Tracking	Satisfactory
5.06	Logbook entries and Shift Report Review	Satisfactory
5.07	Key Control	Satisfactory
5.08	Contraband Procedure	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	Vehicals and Maintenance	Satisfactory
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Satisfactory
5.13	Tool Inventory and Mangement	Satisfactory
5.14	Youth Tool Handling and Supervision	Satisfactory
5.15	Outside Contractors	Satisfactory
5.16	Fire, Safety, and Evacuation Drills	Satisfactory
5.17	Disaster and Continuity of Operations Planning (COOP)	Satisfactory
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.19	Youth Handlins and Supervison of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.20	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.21	Recreation and Leisure Activities	Satisfactory
5.22	*Elements of the Water Safety Plan, Staff Training, and Swim Test	Non-Applicable
5.23	Visitation and Communication	Satisfactory
5.24	Search and Inspection of Controlled Observation Room	Non-Applicable
5.25	Controlled Observation	Non-Applicable
5.26	Controlled Observation Safety Checks and Release Procedures	Non-Applicable

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Program Overview

The Brevard Group Treatment Home is a thirty-bed program, for males, located in Cocoa, Florida. The program is operated by Aspire Health Partners, through a contract with the Department. The program provides mental health overlay services. In addition, the program fosters each youth by providing Life Skills Training (LST), Moral Reconation Therapy (MRT), Impact of Crime (IOC), and Thinking for a Change (T4C). Additional treatment services provided includes individual and family therapy, group therapy, and recreation therapy. Program administration is comprised of a program director and two program managers. Case management services are provided by one case manager and a transitional case manager. Mental health staff at the program includes a licensed mental health counselor (LMHC) who serves as the designated mental health authority (DMHCA), as well as three non-licensed, master's-level therapists. 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 by one licensed practical nurse and one register nurse. The program contracts with a medical doctor who is the program's designated health authority (DHA) and is also qualified to serve as the program psychiatrist. Additionally, the program has a collaborative practice protocol and contract in place with an advanced registered nurse practitioner (ARNP). Educational services are provided by the Brevard County School District. At the time of the annual compliance review, the program had six program specialist positions vacant. The layout of the program includes: an administration building which houses staff offices, master control, three classrooms, and the kitchen/dining hall, the dormitory building which includes shared youth rooms, youth bathrooms, staff offices, and the medical office, and a large recreation field. The program has sixteen operating security cameras providing coverage.

Strengths and Innovative Approaches

- During the annual compliance review period, the program instituted a leisure club where youth are able to sign up for a club every eight weeks which allows them to explore different topics and hobbies. Clubs include Spanish, American Sign Language, workout, bible study, lawn games, arts and crafts, and board games.

- Through an active partnership with the Brevard County Rotary Club, the program has established and maintained a program garden. Further, the Rotary Club assists the program in finding and completing community service projects.

- Representatives from the Boy Scouts of America come to the program once a week to engage youth in activities which help them learn life skills and connect them with opportunities in the community through the Boy Scouts once they leave the program.

Standard 1: Management Accountability

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

The program has a written policy and procedures in place requiring an initial background screening for all newly hired staff, prior to contact with youth. A review of personnel records found six new hires, one volunteer, and one rehired staff eligible for an initial background screening. Each of the seven staff and one volunteer were found with a complete and eligible background screening in the Agency for Healthcare Administration (AHCA) Clearinghouse system prior to their hire dates, none of which required an exemption. The rehired staff had a break in service and all background screening was completed, as required. Additionally, each record had documentation the provider reviewed the criminal history report, Central Communications Center (CCC) person involvement history report, Staff Verification System (SVS) module, and Florida Department of Law Enforcement (FDLE) automated training management system (ATMS). Five of the eight staff and the volunteer were added to the program's roster in the AHCA Clearinghouse. None of the eligible new staff or one rehired staff had a pre-employment assessment tool completed prior to hire. The program reported they did not have a process in place to administer the assessment to applicants. The program submitted their Affidavit for Compliance with Level 2 Screening Standards to the Department on January 23, 2019, meeting the annual requirement. The program's teachers are employed by the school board and submitted their Affidavit for Compliance with Level 2 Screening Standards to the Department January 10, 2019.

1.02 Five-Year Rescreening	Failed 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 written policy and procedures which requires each staff to submit a background rescreening every five years of employment. The program did not have any staff applicable; however, two volunteers were applicable for five-year background rescreening. A review of the Agency for Healthcare Administration (AHCA) Clearinghouse found neither of the volunteers had been rescreened.

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

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

- *Posting of the Florida Abuse Hotline telephone number and the Central Communications Center for youth 18 years of age and older telephone number.*
- *All allegations of child abuse or suspected child abuse are immediately reported to the Florida Abuse Hotline.*
- *Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline pursuant to Section 39.201 (1)(a), F.S.*
- *The environment is free of physical, psychological, and emotional abuse.*
- *A code of conduct for staff who clearly communicates expectations for ethical and professional behavior, including the expectation for staff to interact with youth in a manner promoting their emotional and physical safety.*

The program has a written policy and procedures in place which outlines the provision for an abuse-free environment for youth. Additionally, the program has a code of conduct and affidavit for good moral character, which meets the requirements of Florida Administrative Code, which all staff must sign upon hire. A review of fifteen staff personnel records found each staff had a signed code of conduct and affidavit for good moral character maintained in their record. The program had two allegations of abuse against staff during the annual compliance review period, one of which was substantiated and is currently under investigation, as the case is with the State Attorney's Office. Both incidents were reported to the Central Communications Center (CCC) and the Florida Abuse Hotline. The program's policy requires youth to have unhindered and immediate access to the Florida Abuse Hotline. Five staff were interviewed and each reported the process for youth who wish to call the Florida Abuse Hotline as immediate and said if youth request a call, the supervisor is notified, the supervisor takes the youth to make the call, and assists them if necessary. Five youth were interviewed and each reported they never had to call the Florida Abuse Hotline but felt they could if they needed to. Each of the five youth also reported feeling safe in the program and never hearing the staff intimidate or threaten youth. Three of the youth reported never hearing staff curse; two youth reported hearing staff curse but never at the youth. Two of the five staff also confirmed hearing staff curse but never at the youth; three of the staff reported staff do not curse around or at the youth. An interview with the program director confirmed violating the staff code of conduct may include consequences up to and including termination. The program director also confirmed youth are allowed immediate access to the Florida Abuse Hotline and the youth have access to the number through numerous postings throughout the program. A program tour confirmed the Florida Abuse Hotline, CCC, and 9-1-1 information is posted in multiple locations.

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 two allegations of abuse against staff during the annual compliance review period. One incident was unsubstantiated; however, the staff was placed on administrative leave during the investigation. The other incident was substantiated and referred to the State Attorney's Office. Reviewed documentation supported the program took immediate action and escorted the staff off the premises after the staff's resignation and discovery of the incident. The program has completed an internal investigation and are cooperating with all external investigations related to the incident. An interview with the program director confirmed the actions taken and reiterated the consequences for violating the code of conduct.

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

The program had five Central Communications Center (CCC) reportable incidents during the annual compliance review period, each of which were reviewed. Four of the five reports, three medical incidents and two complaints against staff, were reported to the CCC within two hours of the staff becoming aware of the incident. One report was called into the CCC twenty-four minutes late. Each report was documented in the program's logbook. A review of grievances, incident reports, and youth records found no incidents which should have been called into the CCC but were not. The program director confirmed staff are to call incidents into the CCC within two hours of the incident occurring.

1.06 Protective Action Response (PAR) and Physical Intervention Rate	Limited 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 Protective Action Response (PAR) plan which was submitted to the Department January 30, 2019. The program's PAR rate during the annual compliance review period was 1.12, which is below the statewide residential PAR rate of 1.47. The program had ten PAR incidents during the annual compliance review period, five of which were reviewed. Each of the five reviewed reports were completed the same day as the incident, reviewed by a supervisor and certified PAR instructor, and was placed in a central location within forty-eight hours. Each PAR incident included documentation of a post-PAR interview with the youth within thirty minutes of the incident. Two incidents required a medical review for the youth, each of which were completed on the same day as the incident. One incident was applicable for an injury and a call to the Central Communications Center (CCC) and Florida Abuse Hotline, which was completed. Four of the five reports were reviewed by the program director designee within seventy-two hours; one report was not reviewed by the program director. Two reports had a

narrative from all staff involved. Three of the reports only included narratives from one of the multiple staff involved. One of these three reports only had one narrative completed by a staff member who was not involved in the event and was dated on a day different from the day the incident occurred. None of the incidents required the use of mechanical restraints. The program submitted their monthly PAR reports by the fifteenth of each month for each month of the annual compliance review period.

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

The program has a pre-service training plan which was submitted to the Department and approved on February 8, 2019. The plan for 2018 was submitted and approved on April 10, 2018. Five staff training records were reviewed for pre-service requirements and each were found to have completed all required training in cardiopulmonary resuscitation (CPR)/first aid/automated external defibrillator (AED), protective action response (PAR), ethics and professionalism, suicide prevention, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA) trainings prior to contact with youth. Each staff was found to have over 120 hours of pre-service training during the first 180-days of employment. All trainings were documented into the Department's Learning Management System (SkillPro) except for on-the-job training for two of the five staff reviewed. Additionally, six trainings for one staff, two trainings for one staff, and one training for a third staff member were not documented in SkillPro but were able to be verified through the staff's training records. Documentation of qualifications for instructors of CPR/first aid/AED were provided. The PAR trainings were taught by a program employee who no longer works for the provider and who qualifications could not be provided. The program did provide documentation of the program manager's qualifications who recently completed training to be the program's PAR trainer.

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

The program has an in-service training plan which was submitted to the Department and approved on February 8, 2019. The plan for 2018 was submitted and approved on April 10, 2018. The program director maintains a calendar which outlines all staff in-service training throughout the year and can be amended, if necessary. Five staff training records were reviewed for in-service training requirements. Each of the five staff completed training in ethics. Three of the five staff were applicable for and completed training in cardiopulmonary resuscitation/first aid/automated external defibrillator. Additionally, each of the five staff completed all trainings required by the program's contract. Three of the five staff did not have documentation of completion of a Protective Action Response (PAR) refresher in the Department's Learning Management System (SkillPro) nor in their training records. Each of the three staff had a PAR exam but no documentation the training was completed. Two of the five staff did not complete suicide prevention part I, and three of the five staff did not complete suicide prevention part II in SkillPro. Two staff were applicable for supervisory training. One staff

had nine hours of supervisory training in management, leadership, employee relations, and communication skills. One staff had seven of the required eight hours in leadership. Each of the five staff training records reviewed included multiple trainings not entered into SkillPro. Documentation of qualifications for instructors of CPR/first aid/AED were provided. The previous PAR sessions were taught by a program employee who no longer works for the provider and whose qualifications could not be provided. The program did provide documentation of the program manager's qualifications who recently completed training to be the program's PAR trainer.

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 written policy and procedures in place which outlines the grievance process and includes an informal, formal, and appeal phase. Youth are encouraged to resolve the issue through an informal phase, which can include filling out a chat form to speak with a staff member regarding the issue. If the grievance is not resolved in the informal phase, youth may complete a complaint form which is then processed and responded to within seventy-two hours by program administration. The youth is then asked to sign the form and check a box whether they agree or disagree with the resolution. If the youth is not satisfied, they may appeal the decision and the program director will respond. The program had four grievances during the annual compliance review period, each of which was responded to within twenty-four hours of submission. The youth agreed with the resolution in each of the grievances. Five youth were interviewed and none have ever had to fill out a grievance. Five staff were interviewed and each confirmed the grievance process. An interview with the program director also confirmed the program's process for grievances, including all three phases. Additionally, a program tour revealed grievance forms are stocked in the dining hall and on the dorm.

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

The program has a policy and procedures regarding delinquency interventions and facilitator training. The program director identified Life Skills Training (LST), Moral Reconation Therapy (MRT), and Impact of Crime (IOC) as delinquency intervention models, evidenced-based models, and/or promising practices provided by the program. The program also utilizes the evidence-based Thinking for a Change (T4C) curriculum. Six staff training records were reviewed. Two staff were trained to facilitate T4C. Both T4C facilitators have master's-level degrees and over ten years of experience working with youth. Three staff were trained to facilitate IOC. Two staff obtained bachelor's-level degrees and one staff obtained a master's-level degree with three to five years of experience working with youth. Two master's-level staff were trained to facilitate MRT, in which one staff had eight years of experience and the other staff had over twenty years of experience working with youth. An interview with the program

director indicated the staff member's work experience and/or education level determines which staff meet the requirements to deliver life skills training or conducting groups. Staff's ability to maintain control and order will also determine if a staff member can facilitate groups. In addition, the program director indicated clinical and case management conduct an assessment upon the youth's arrival to the program. Based on the youth records and an interview with the youth, a determination is made to match the youth with therapist, case manager, and intervention groups.

The program's activity schedule determined youth spend at least sixty percent of their awake hours in structured, planned programing and/or activities. A review of the sign–in sheets during the annual compliance review period indicated T4C groups were delivered, as designed; however, MRT group sign-in sheets indicated the program did not meet the required forty-five-hours as, required. The program facilitated two cycles of MRT during the six-month review period. The first cycle started on July 16, 2018 and ended on October 8, 2018 which covered approximately twelve hours. The second cycle started on October 8, 2018 and ended on January 14, 2019 which covered approximately thirteen hours. The deficiencies were discussed with the Department during the Standard Program Evaluation Protocol (SPEP) call reviewing reports from Fiscal Year 17/18 on January 3, 2019 and technical assistance was provided on January 11, 2019. The program implemented internal corrective action to ensure future delinquency groups comply with the SPEP guidelines. Five youth records were reviewed which indicated all five youth completed MRT group. All five youth assessments identified delinquency intervention as a priority need. All five youth performance plans included delinquency intervention goals.

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

The program has a policy and procedures regarding the facilitation of Life Skills Training (LST) to the youth. The designated mental health clinical authority (DMHCA) identified LST, Communication Skills, Anger Management, and Mindfulness for the Adolescent were provided to the youth during the annual compliance review period. The life skills groups specifically addressed communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking. Youth are assessed during the intake process and placed in groups which meet their criminogenic needs. A review of the activity schedule confirmed life skills groups were provided, as designed. A review of LST sign-in sheets verified youth received life skills training, as required by the program's contract and the youth's treatment plans. All staff facilitating groups have been trained in the curriculums. The program director and DMHCA were interviewed and both stated youth can practice skills in group role-play activities and interactions with staff and youth at the program. Five youth were interviewed and each confirmed they were able to demonstrate the skills they had learned by doing role play activities during groups and treatment team meetings, as well as in interactions with staff and peers at the program. A review of five youth records indicated all five were participating life skills training groups.

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 regarding providing restorative justice awareness to the youth. The program provides the Impact of Crime (IOC) curriculum to the youth. IOC is designed to assist youth to accept responsibility for harm they have caused by their past criminal actions, teaches youth about the impact of crime on their victims, their families, and their communities, exposes youth to victim's perspectives through victim speakers, in person or through DVD videos, and provides opportunities for youth to participate in reparation activities such as community service projects, writing letters to military personnel and writing letters of apology to the victims. A review of training records verified staff facilitating IOC groups were trained in the curriculum. An observation of an IOC group was conducted during the annual compliance review. The facilitator followed the curriculum, was confident facilitating group, and had class management skills. The youth participated in the discussion and activities. The program's activity schedule verified the IOC groups were provided, as scheduled; however, group sign-in sheets indicated the program was not delivering the curriculum as designed. The deficiencies were discussed with the Department during the SPEP call reviewing reports from Fiscal Year 17/18 on January 3, 2019 and technical assistance was provided on January 11, 2019. The program implemented internal corrective action to ensure future restorative justice groups comply with the SPEP guidelines. The program director was interviewed and provided additional restorative justice activities provided to youth, which includes guest speakers, youth ministry activities, and community service projects, to receive exposure through the victim's perspective and bring restoration to the community. Five youth records were reviewed, and all five youth were attending or had completed IOC groups.

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

The program provides Young Men's Work (YMW) as the gender-specific curriculum to the youth. YMW addresses the needs of young men and is designed to provide services on the common characteristics of young men. The curriculum was reviewed and verified the material is appropriate to instruct on gender-specific issues. A review of the program's activity schedule, treatment notes, and group sign-in sheets confirmed gender-specific programing is provided to the youth. An interview with the program director indicated the program provides YMW curriculum to the youth. The nurse also conducts group discussions with youth about male development and changes to the body. Additionally, the Boy Scouts of America come to the program once a week and provide services and activities to the youth. The Men of Distinction come to the program to teach youth skills such as dinning etiquette and tying a tie.

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 written policy and procedures in place establishing a system for maintaining, updating, and sharing alert information. Each day, on each shift, the program updates the alert list and places it in the alert binder, which is accessible to staff. Each staff on shift must sign their shift's alert list, acknowledging they are aware of any alerts. Five staff were interviewed and each confirmed the process for being informed of alerts was "good." Entering and closing alerts is the responsibility of each discipline, the clinicians open and close mental health alerts, medical staff opens and closes medical alerts, and case management opens and closes safety and classification alerts. A current alert list was compared to the alerts documented in the Department's Juvenile Justice Information System (JJIS) and found all alerts were consistent. Five youth records were reviewed and four were applicable for alerts entered and downgraded by the program. Each of the four youth records reflected the alert was downgraded by appropriate staff and documented in the shift briefing and on the corresponding shift alert list. One alert was ended on September 11, 2018 and not updated in JJIS until September 18, 2018 and another was ended October 18, 2018 but was not updated until October 22, 2018. Two youth were applicable for the alert to be entered into the logbook and each were found. One youth has an alert which affected classification and it was entered, as required. All alerts were verified prior to entering into 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 maintains separate case management, medical, and mental health records. Each record is marked as "confidential" and labeled with the youth's name, Department identification number, date of birth, county of residence, and committing offense. The case management records are divided into legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous sections. The case management records are kept in a locked filing cabinet in the case management office, the mental health records are kept in a locked filing cabinet in the mental health office, and the medical records are kept in a locked filing cabinet in the medical office. All filing cabinets are marked as "confidential".

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

The program has a written policy and procedures in place which allow youth to provide input into program planning. During the annual compliance review period, the program changed their process of youth input from a youth advisory board to administering youth surveys each month to all youth. Surveys were found and reviewed from September through January. Further, meeting minutes were found for weekly in-house meetings in the dorm each Wednesday. These in-house meetings provided staff and youth opportunities to address any issues and provide feedback. Five youth were interviewed and each reported they were able to provide input into the program including through surveys, in-house meetings, and talking to the program director.

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

The program has a written policy and procedures in place establishing a community advisory board. The program held advisory board meetings quarterly during the annual compliance review period. The advisory board includes active representatives from a defense law firm, the school board, the business community, military, faith community, and two parents of youth who had been committed to juvenile justice programs. Each of these members regularly attended all advisory board meetings. Participation was not found for a member of the judiciary, law enforcement, or a victim advocate or victim. Documentation was provided of letters attempting to solicit these members, including letters sent out to newly identified potential members in an effort to get them to attend the next meeting. Additional letters were provided which had conflicting meeting dates; however, updated letters were provided and resent to potential members. Meeting minutes were found to support topics discussed at the advisory board meetings which included items needed at the program, community service opportunities, and program updates. An advisory board member who had been a part of the board for five years was interviewed by telephone during the annual compliance review. The member discussed he was an attorney and member of the Merritt Island Rotary Club and was active in helping connect youth to local rotary clubs. Further, the member helps to establish and maintain a garden at the program and organized having youth assist in community clean-up projects.

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 written policy and procedures in place regarding program planning and incorporating feedback into the program. Monthly reports were found to be submitted to the Department's contract manager each month and all required data was maintained and shared. Staff meeting minutes demonstrated administration has shared results of reports, including the last annual compliance report, and incorporating it into program planning. Staff meetings are held each month and cover training, updates, and sharing of program information. Surveys are obtained from youth on a monthly basis, staff periodically, and parent/guardians when able. Surveys and recommendations are also incorporated into program planning. The program has a morale committee which plans different events and creates ways to engage staff and increase retention. Efforts of the morale committee are shared with all staff during staff meetings. Further,

the provider utilizes a VIP reward system where staff are recognized for exceptional work and rewarded through different incentives.

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 written policy and procedures outlining the requirements for annual staff performance evaluations. Five staff personnel records were reviewed and each included a signed position description which gave a brief overview of job duties. The position description was used as the basis for the annual evaluations found in each of the five staff records. The program director was interviewed and confirmed the performance evaluation process.

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 addressing initial telephone contacts to a youth's parent/guardian within twenty-four hours and written notifications to the youth's parent/guardian, committing court, and assigned juvenile probation officer within forty-eight hours. A review of five youth case management records found each record documented the parent/guardian was contacted by telephone within twenty-four hours of admission and in writing within forty-eight hours of admission. The program notified the youth's juvenile probation officer, committing judge, and state attorney's office within forty-eight hours of the youth's admission. Each letter was signed by the program director.

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 addressing youth orientation to the program. Orientation is to be conducted within twenty-four hours of admission to include a review of the program rules, procedures, schedules, expectations, goals, and services. Five reviewed youth case management records reflected a client handbook, contraband form, and a client orientation checklist was signed by the youth and the case manager/transition coordinator on the date of the youth's admission. The orientation checklist documents a review of the services available, an overview of the schedule, access to medical and mental health services, access to the Florida Abuse Hotline, items considered contraband, and the dress code. The orientation checklist also documented the procedures for visitation, mail and use of the telephone, the anticipated length of stay, community access, grievance procedures, and emergency procedures were discussed with the youth. Each orientation checklist documented the youth was given a tour of the facility and was assigned to a counselor and a mentor. The orientation checklist indicated the youth handbook was thoroughly reviewed with the youth and a copy of the handbook was provided to the youth. The youth handbook was reviewed, which included an overview of the behavior management system, hygiene practices, and youth rules and expectations. The orientation provided to the youth included all of the elements, as outlined in the program's policy. There were no youth admissions during the annual compliance review to observe. A review of logbooks reflected the program documented each youth's admission and when the intake was completed. Five youth interviewed reported they each were given an orientation within twenty-four hours of admission into the program.

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 the annual compliance 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 that may be used as potential weapons or means of escape, or participation in any off-campus activity.*	

The program has a policy and procedures addressing the initial classification process to assign newly admitted youth to a living unit, sleeping room, and youth group or staff advisor. According to policy, after five to fourteen days, a room assessment is completed to assign the youth a room. Five youth case management records were reviewed, and four of five records documented an initial classification was completed on the date of the youth's admission. The remaining record documented the classification took place ten days after admission. The program cited this was an unintentional error by staff regarding the date. Each classification form identified factors such as the youth's physical characteristics, age, maturity level, special needs, history of violence, gang affiliation, criminal behavior, and vulnerability to victim and sexual aggression, as identified by the Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB). The program also conducts monthly VSAB re-assessments. Each record documented any suspected risk factors to include suicide risk, medical risk, escape risk, and a documented review of the Department's Juvenile Justice Information System (JJIS) alert list for any issues affecting classification. Each youth was identified and placed on a high security observation and was assigned to sleep in the common area until the program manager/designee consulted with the treatment team. The program completed a Youth Room Assignment, Class "B" Tool, and Risk Assessment form for each youth within the fourteen day requirement. The assessment identifies if the youth is appropriate and eligible for room assignment, and which room they are assigned to. Documentation provided by the program indicated a request for transportation and security risk assessment form was completed for each youth. The assessment addresses the youth's eligibility for off campus activities, home visits, field trips, and the youth's security risk. An interview with the program director reflected the program utilizes the VSAB, Massachusetts Youth Screening Instrument-2 (MAYSI), and other information on the youth's face sheet when assigning a youth to a room. The program director confirmed upon admission the youth must sleep in the dayroom prior to being assigned to a room. The program has an internal alert system which is updated daily and is easily accessible to the program staff. One youth record reflected the youth was Baker Acted upon admission on August 23, 2018; however, an alert was not entered into JJIS until October 8, 2018 after the

program identified the error in an internal audit review. The remaining applicable alerts were entered, as needed.

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 requiring the notification of law enforcement whenever a youth is identified as gang involved. Two of five youth case management records reviewed were applicable for youth identified as gang members or were suspected of being affiliated with a gang; therefore, an additional record was requested. Each record reflected local law enforcement was notified of the suspected gang involvement, to include law enforcement in the youth's home county. Each youth was identified as having gang involvement prior to the youth's placement in the program. Each case management record documented the local school district and the youth's assigned juvenile probation officer were notified of the youth's suspected or documented gang involvement. A review of the Juvenile Justice Information System (JJIS) reflected the youth all 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 addressing the implementation of gang prevention and intervention strategies. According to program's policy, the gang liaison is to implement gang prevention and intervention strategies when youth are identified as a gang member, having gang affiliation, or are at a high risk for gang involvement. Two of five youth case management records reviewed were applicable for youth identified as gang members or were affiliated with a gang; therefore, an additional record was requested. Two of three records contained a relevant goals or objectives relating to gang intervention strategies on the performance plans. One youth's initial performance plan did not include a relevant goal relating to gang intervention strategies; however, a goal was added to the youth's subsequent performance plan. The program director who is also the program's gang liaison, conducted bi-weekly gang awareness groups from October 3, 2018 to January 23, 2019. The program utilizes Phoenix/New Freedom Programming which includes lessons regarding retaliation, what's getting the youth in trouble, dealing with disrespect, keeping focus on what's important, loyalty, and what the youth will do when they return home.

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

The program has a policy and procedures addressing the completion of an initial Residential Positive Achievement Change Tool (R-PACT) assessment within thirty days of admission. Five youth case management records reflected an R-PACT was completed within thirty days of the youth's admission and each was maintained in the Department's Juvenile Justice Information System (JJIS). Four of five records contained R-PACT Re-Assessments completed within ninety days of the initial R-PACT and each subsequent ninety days. One record did not contain a R-PACT Re-Assessment, which was due January 31, 2019 and had not yet been completed. The program maintained all completed reassessments in the youth's case management record. Updates or reassessments were completed when deemed necessary, with the exception of the one overdue re-assessment.

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

A review of five case management records reflected each record contained a Youth Needs Assessment Summary (YNAS) completed within thirty days of the youth's admission. Each YNAS was documented in the Department's Juvenile Justice Information System (JJIS). Each YNAS was signed by the individual completing the assessment.

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 addressing performance plan development, goals, and transmittal of plans. Five youth case management records were reviewed, and each record contained an Individualized Performance Plan developed within thirty days of the youth's admission. Each record contained a performance plan development form signed by the youth, treatment team leader and pertinent staff participating in the meeting. Each performance plan

was developed after the initial assessment. Each performance plan documented the treatment team leader, youth, administrative representative, direct care staff, treatment staff, and educational staff were present during the development of the Individualized Performance Plan. Each performance plan was signed by all required parties. Each plan was mailed to the youth's parent/guardian; however, only one was returned by the parent/guardian with a signature. Each performance plan contained individualized goals based on the youth's needs, and each plan addressed each of the youth's top three criminogenic needs. Each plan addressed specific delinquency interventions for the youth to participate in, such as Impact of Crime, Moral Recognition Therapy, or Life Skills Training. One of the five records was applicable for outstanding court-ordered sanctions, which were included on the youth's performance plan. Each plan included transition activities targeted for the last sixty days of the youth's stay, as well as, the youth's responsibilities, staff responsibilities, and target dates for goal completion. Two performance plans for one youth contained a projected end date for a youth intervention which was prior to the intervention's start date and prior to the youth's date of admission. The first performance plan was hand corrected, and the end date was updated during the annual compliance review in the Department's Juvenile Justice Information System (JJIS) for the youth's third performance plan. Each record contained documentation 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 were able to identify program's treatment process including the development of the performance plan, treatment team meetings, and the goals they are currently working on. Each youth reported they have been provided a copy of their performance plan.

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

Five youth case management records were reviewed for revisions to the youths' performance plans. Each record documented the performance plan was revised when the youth demonstrated progress toward completing a goal, or lack of progress toward completing a goal. Revisions are made, when needed, to facilitate transition activities during the last sixty days of the youth's stay.

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.*	

Four of five records were applicable for requiring a performance summary and a total of five performance summaries were completed. Each record documented performance summaries were completed at intervals of at least ninety days following the signing of the performance plan. One of the five youth records was applicable for a performance summary prior to the youth's release, which was also completed. Each reviewed performance summary contained the status

of each performance goal, the youth's overall treatment progress, academic status, behavior, and level of readiness to change. Three of the five completed performance summaries included the youth's interaction with peers; the two remaining summaries did not. Each performance summary included the youth's overall behavior adjustment in the program, and positive and negative events. Each youth was able to read and add comments prior to signing the summary. Four of the five performance summaries included comments written by the youth. Each case management record contained the original signed summary, and copies were provided to the youth. Each performance summary was signed by the treatment team leader, staff member preparing the summary, the program director, and the youth. Four of the five performance summaries were dated, with one summary not dated by the staff preparing the summary. Each youth record contained a letter and documentation 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 discharge performance summaries. Two of the three records contained an original signed discharge summary and the remaining record contained a copy of the release summary. Each discharge summary was 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. Each record contained documentation of written notification to the parent/guardian once the PRN was approved by the court. A check of the Department's Juvenile Justice Information System (JJIS) reflected each youth had an Exit Residential Positive Achievement Change Tool (PACT) completed by the program after the PRN was approved and prior to the youth's release date. The program is not applicable for sexually violent predators and none of the youth were applicable for victim notification or a denied PRN. Four of five interviewed youth reported they received a copy of the performance summary sent to the court. The remaining youth was not applicable for a performance summary.

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

The program has a policy and procedures addressing the importance of the parent/guardian's integration in the treatment process. According to the program's policy, the program makes efforts for bi-weekly contact with family, conduct special family counseling, and have monthly family reunification. The program sends letters to the parent/guardian encouraging them to take part in their child's progression through the program. The program maintained documentation of letters mailed to the parent/guardian upon admission which explains the program and the importance of family being involved in the development of the performance plan, treatment plan, and treatment team meetings. The program encourages the parent/guardian's involvement in the assessment process, participation in the development of the youth's performance plan, formal treatment teams, and transitional planning. Three treatment teams and one transitional staffing were observed during the annual compliance review and the parent/guardian and the youth's juvenile probation officer (JPO) were contacted by phone for each meeting. An interview with the program director indicated the parent/guardians are encouraged to take part in their child's treatment team, family counseling sessions, and family reunification visitation. Five interviewed youth reported their parent/guardian is involved in the case management process to include 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 addressing the members of treatment team to include representatives from the program's administration and residential unit, education staff, and others directly responsible for providing or overseeing intervention and treatment services to include the juvenile probation officer (JPO), and the parent/guardian. Documentation of treatment team meetings reflect participation from the youth, clinical manager, residential case manager, program manager, program director, program specialist, youth counselors, transitional services manager, education, nursing, recreation therapist, the JPO, and parent/guardian, if available. When the program manager, director, or nursing staff were not available to attend the treatment team meeting, they provided written information to the team and the reports were reviewed. One record applicable for involvement with the Department of Children and Families (DCF) was reviewed. Documentation indicated the youth's case worker was involved in the youth's treatment team meetings and made face-to-face contact with the youth at the program on a regular basis.

Observations of three treatment team meetings found staff in attendance included the clinical director, therapists, case manager, transition service manager, the youth, the recreation therapist, and a representative from education. The parent/guardian and JPO were contacted by telephone and participated, if available. The treatment team meetings did not include an administrative representative or living unit representative. Documentation from the treatment team meetings reflected the program manager and program director reviewed the report, and documentation was provided for the team by the program specialist. The program reported administration was not present due to the annual compliance review and the program would have been out of ratio if a program specialist attended the treatment team meetings; however, treatment team review forms showed these representatives attended each of the written treatment team documentation reviewed for each youth.

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.	

Five youth records were reviewed for the incorporation of treatment plans into the performance plan. Three of the five youth records were applicable for an academic plan, which was incorporated in each performance plan. All five youth records were applicable for separate treatment plans, to include a substance abuse or mental health plan, which was incorporated in each youth's performance plan. None of the records were applicable for involvement with the Department of Children and Families or the Agency for Persons with Disabilities; therefore, an additional record was reviewed. The program only had one youth involved with the Department of Children and Families. Documentation indicated the youth's treatment plan was incorporated into the performance plan and there was coordination with the youth's case worker at least once every month, in person or by telephone.

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

Five youth case management records were reviewed for treatment team meetings. The program has a policy and procedures indicating the program conducts bi-weekly formal treatment team meetings. A review of each record reflected the parent/guardian, juvenile probation officer, and the committing judge were invited and encouraged through advanced notification to attend treatment team meetings. Formal treatment team meetings were documented in each record as being conducted on a bi-weekly basis and each treatment team report included the youth's name, date of the review, and the meeting attendees. Formal performance reviews document the youth's progress toward the completion of treatment plan, the youth's stage of change with the target dates, a therapeutic summary, family progress, academic progress, medical information, behavioral progress, transports or special activities, good reports, and any problem behavior reports. The treatment team report also indicates if an assessment has been completed for Class B tools, and for off-site privileges. The youth's current phase is identified, if any Protective Action Responses (PARs) were utilized, any monthly awards, youth requirements, special alerts, parent/guardian contact, and the youth's goals were also identified on the treatment team report. Five youth interviewed reported they were given the opportunity during treatment team meetings to demonstrate any skills they have learned in the program.

Three treatment team meetings were observed during the annual compliance review. In attendance at each meeting was the clinical director, therapists, case manager, transition service manager, the youth, the recreation therapist, and education. The parent/guardian, and juvenile probation officer were contacted by telephone and participated, if available. Treatment team documentation and observations confirmed the youth's progress, positive and negative behaviors, treatment progress, and education progress were discussed. During observations of the treatment team meetings, each party gave a brief update on the youth's progress to include the youth, therapists, education, and case management. The treatment team meetings did not include an administrative representative or living unit representative; however, this was due to ratio requirements. Documentation from the treatment team meetings reflected the program manager, and program director reviewed the report, and documentation was provided for the team by the program specialist.

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

The program provides type 2 career education programming. My Career Shines is provided and offers all youth an opportunity to explore and gain information about a variety of different occupations. Vocational certificates are offered to youth ages fifteen and older. The certification available is the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens

Certification. The five active and three closed youth records reviewed included only thirteen and fourteen-year old youth. Since the age group of this population targets a younger set of youth, most are not appropriate for employability goals; however, the three closed records included sample job applications and sample resumés. The interview with the lead educator revealed all youth complete the sample resumés and job applications, but if a youth is age appropriate for employability goals, they are prepared using more extensive materials.

2.17 Educational Access	Limited 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 250-day school calendar which is spread out over a twelve-month period. The bell schedule provided at the beginning of the annual compliance review revealed the youth were receiving twenty-three and a half hours of education instruction each week, which was confirmed through a review of the logbook. Once this was identified, an updated bell schedule was provided with twenty-five hours of instruction a week. Further review of the logbooks, as well as interviews with the youth and lead educator, verified the school schedule is adhered to and there is very little interference to the school day.

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

Five youth closed records were reviewed and each included education transition plans with the required individuals involved and notified. The Brevard County School District is involved with reviewing the transcripts upon entry and assessing the individual educational needs of the youth. The educational transition plans addressed the youth's current educational status, as well as, the educational goals during the youth's stay in the program. The lead educator is involved with the treatment team meetings, as well as the Community Re-Entry Team (CRT) meetings and shares current educational information for each youth at those meetings. The CRT meetings provide an opportunity to discuss and focus on the most appropriate educational placement for the youth upon their release. Due to the age of the youth served at this program, most do not have employability as a 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.*	

Two of the five youth management records reviewed were applicable for a transition conference and each were completed as required. One of the applicable youth's transition conference was able to be observed during the annual compliance review. The conference was held at least sixty days prior to the youth's targeted release date in each record. In attendance at the transition conference were the youth, treatment team leader, case manager, education, and the youth's therapist. The juvenile probation officer (JPO) and parent/guardian were contacted by telephone for participation. The youth's performance plan, transition activities, progress in therapy, progress in education, and recommendations for release were discussed. A Community Re-Entry Team (CRT) meeting for another youth was also observed during the annual compliance review. The CRT was conducted by a JPO and the program called in to participate. The program staff in attendance at the CRT included the youth, an education representative, the transition service manager, and the youth's therapist. The CRT was conducted prior to the youth's release and exit conference.

Three closed records were reviewed for transition planning. Each record contained documentation a transition conference was conducted at least sixty days prior to the youth's targeted release date. The transition plan indicated the youth, treatment team leader, education, and clinical staff were in attendance. The juvenile probation officer, parent/guardian, education, and all other pertinent parties were encouraged to participate in the transition staffing. Reviewed documentation indicated the youth's transportation home, progress/needs, aftercare conditions, education, post-commitment recommendations, medications, further actions required, and the exit portfolio were discussed at the transition conference for each youth. The transition plans identified target completion dates, and the persons responsible for completion. Each record contained a signature page and dates of attendees. Each record documented a copy of the plan was sent to the youth's parent/guardian, juvenile probation officer, and committing court. Each record documented the program's attendance at the youth's Community Re-entry Team (CRT) meeting. Each CRT meeting was conducted prior to the youth's release and a copy of the outlook invite was maintained in each record.

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 addressing the completion of an exit portfolio for each youth upon release from the program. According to policy, the exit portfolio is to be discussed and initiated at the transition conference and the program will forward the exit portfolio information to the juvenile probation officer and document the information in the youth's case management record. Three closed records were reviewed for exit portfolios. Each record documented the exit portfolio was discussed at the transition conference. Each exit portfolio contained a calendar with dates and appointments for the youth, school transcripts, education records, a resumé, and three sample job applications despite the youth being under the age of fifteen. The education staff forwarded the exit portfolio information to the receiving school district. None of the records contained a state-issued identification card; however, two of the three records documented the parent/guardian did not supply documentation to obtain a state-issued identification card. Each record documented the youth was too young for vocational certificates. Each exit portfolio was verified at the exit conference. Two of 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. One of three records contained confirmation the juvenile probation officer was forwarded the exit portfolio information and the remaining two records did not contain documentation the exit portfolio was forwarded to the juvenile probation officer.

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

The program has a policy and procedures addressing exit conferences for youth prior to their release from the program. According to policy, the case manager is to schedule and conduct the exit conference within fourteen days from the youth's discharge date. Three closed youth records were reviewed for exit conferences. One record reflected the exit conference was conducted at least fourteen days prior to the youth's release. One record contained a calendar invite indicating the date of the exit conference; however, the record did not contain any documentation from the exit conference to include who was in attendance or what was discussed at the conference. The program was able to provide documentation the exit conference occurred through youth case notes and an e-mail from the juvenile probation officer (JPO), within the required timeframe, but did not have the exit conference documentation to confirm what was discussed and verify attendees. The remaining record documented an exit conference was conducted nine days prior to the youth's release. Two of three records documented the date and signatures of individuals who attended the exit conference which included the transition service coordinator, the youth, education staff, medical staff, the clinical manager, the counselor, and the program director. The exit staffing form in each of the two records listed the youth's recommendation post-release and any applicable aftercare conditions for post-commitment probation or conditional release. None of the exit conference forms documented the parent/guardian was present; however, each were contact by telephone. The Department's Juvenile Justice Information System (JJIS) reflected the date of admission and date of termination documented in each youth's record matched the dates documented in JJIS.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a licensed clinical social worker (LCSW) who serves as the program's designated mental health clinician authority (DMHCA). The DMHCA has a clear and active license in the State of Florida, with an expiration date of March 31, 2019. The DMHCA is full-time, working on-site, at a minimum of forty hours a week. The DMHCA is on-call twenty-four hours a day, seven days a week, and is responsible for the coordination and implementation of mental health and substance abuse services. An interview with the DMHCA revealed the DMHCA provides ongoing training, supervision, internal auditing and recommendations regarding treatment and interventions used by the program. The DMHCA is responsible for assisting the director in implementation and fidelity of Standardized Program Evaluation Protocol (SPEP) and evidence-based services.

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

The program has one licensed clinical social worker (LCSW) who serves as the director of clinical services and the designated mental health clinician authority (DMHCA). The DMHCA has a clear and active license in the State of Florida, with an expiration date of March 31, 2019. The DMHCA is on-site at a minimum of forty hours a week.

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 three non-licensed, master's-level therapist. One has a degree in counselor education and the other two have degrees in counseling. Each clinician works under the direct supervision of the designated mental health clinician authority (DMHCA). A review of the clinical supervision log from August 2018 through January 2019 found the non-licensed mental health staff received at least one hour of face-to-face direct supervision from the DMHCA each week.

The reviewed documentation reflected the clinical supervision log included all required elements, as outlined in Chapter 397, Florida Statutes. The form utilized to document the direct supervision includes all information as outlined on the Department's form. The reviewed forms supported a review of each clinician's case load, clinical services provided, documentation, miscellaneous directions, instructions, and recommendations. All non-licensed clinical staff received twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention and emergency mental health services.

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

The program has a policy and procedures regarding each youth receiving an intake mental health assessment upon admission. Each of the five youth records reviewed had a completed Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) which was conducted at admission. The case manager and transition services manager were trained in the administration of the MAYSI-2. The case manager and transition services manager review all commitment information. Each of the MAYSI-2 assessments were entered in the Department's Juvenile Justice Information System (JJIS). Three of the five MAYSI-2 results indicated need for an Assessment of Suicide Risk (ASR). All three applicable ASRs were completed within twenty-four hours of indication of need. Each youth received a new comprehensive mental health and substance abuse bio-psychosocial evaluation. The bio-psychosocial evaluation included comprehensive mental health and substance abuse use, emotional and behavioral functioning, social roles, and other areas impacting the youth's overall level of functioning. The program director reported youth are administered the MAYSI-2 and ASR, if needed, at admission. Each assessment is reviewed and signed by the licensed clinician. Youth are provided a Brief Behavioral Status exam and comprehensive assessment along with psychiatric assessment to assist staff in treatment planning.

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

The program has a policy and procedures regarding the assessment process of each youth entering the program. The program completes a new Comprehensive Bio-Psychosocial Evaluation which combines both the youth's mental health and substance abuse information into one document. Five youth records were reviewed and each had a completed Comprehensive Bio-Psychosocial Evaluation completed within thirty days of their admission. The designated mental health clinical authority reviewed and signed all evaluations within ten calendar days. Each of the five evaluations included all required elements. Each record also contained a signed Youth Consent for Substance Abuse Treatment and Youth Consent for Release of Substance Abuse Treatment Records. The program is licensed through the Department of Children and Families (DCF) in accordance with Chapter 397, Florida Statutes, to provide substance abuse services for outpatient treatment. The current license expires May 23, 2019.

3.06 Mental Health and Substance Abuse Treatment	Satisfactory Compliance

Mental health and substance abuse treatment planning in Departmental facilities focuses on providing mental health and/or substance abuse interventions and treatment to reduce or alleviate the youth's symptoms of mental disorder and/or substance abuse impairment and enable youth to function adequately in the juvenile justice setting.

The treatment team is responsible for assisting in developing, reviewing, and updating the youth's individualized and initial mental health/substance abuse treatment plans.

The program has a policy and procedures requiring each youth entering the program to receive mental health and/or substance abuse treatment. Five youth records were reviewed. Upon admission to the program, each of the five youth was assigned to a treatment team. The treatment team members included the program's administration, a living unit representative, education, medical, mental health and other staff responsible for treatment services. Three treatment teams were observed during the annual compliance review and found all required members were in attendance, except for administration and living unit representatives. Five youth mental health records were reviewed and found each received individual, group, and family (if applicable) counseling by a non-licensed clinical staff working under the direct supervision of the designated mental health clinician authority (DMHCA). All five youth had properly executed Authority for Evaluation and Treatment (AET) forms in their records. The mental health and substance abuse progress notes were documented on a form which contained all of the information on Department form MHSA 018. Documentation found each mental health group included ten or less youth participants and fifteen or less for substance abuse groups. Each of the five youth received individual therapy according to their treatment plans. All youth received a psychiatric evaluation within seven days of admission. Medication management was conducted every thirty days for applicable youth prescribed psychotropic medications. During the annual compliance review, one mental health group was observed. The group had ten youth in attendance. Five staff were interviewed and each reported direct care staff do not facilitate any mental health or substance abuse groups. The therapists facilitate all group therapy. The DMHCA confirmed all youth receive individual and group therapy; however, family therapy occurs when the youth is getting ready for discharge.

3.07 Treatment and Discharge Planning (Critical)	Satisfactory Compliance

Youth determined to have a serious mental disorder or substance abuse impairment, and are receiving mental health or substance abuse treatment in a program, shall have an initial or individualized mental health or substance abuse treatment plan. When mental health or substance abuse treatment is initiated, an initial or individualized mental health or substance abuse treatment plan is completed.

All youth who receive mental health and/or substance abuse treatment while in a residential program shall have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services upon youth's release from the facility.

The program has a policy and procedures outlining the requirements for youth to receive treatment services and discharge planning. A review of five youth mental health and substance abuse records confirmed an initial mental health and substance abuse treatment plan was developed for each youth on the date of admission. The initial treatment plan was documented on a form which included all required elements from the Department's form. The initial treatment

plans were signed by treatment team members, including the mental health clinical staff. Each youth record also contained an individualized mental health and substance abuse treatment plan completed within thirty days of the youth's admission to the program. The individualized mental health and substance abuse treatment plan is developed by the treatment team based upon the areas of need identified within the comprehensive mental health and substance abuse bio-psychosocial evaluation. The individualized plan was documented on an individualized mental health/substance abuse treatment plan form which contained all of the information on the MHSA 016 form. Each of the five plans were signed by all treatment team members. For youth applicable for psychiatric services, the treatment plans included psychiatric services. Each of the five youth records included documentation the youth received treatment team reviews twice per month.

Three closed youth records were reviewed for discharge planning. All three youth received mental health and/or substance abuse treatment while in the program before discharge. None of the youth were discharged with a suicide risk alert. Each of the discharge summaries documented the youth's mental health and substance history and reason for recommending on-going treatment. Each reviewed discharge summary contained recommendations for continuing mental health and/or substance abuse treatment within their home community along with applicable referrals for continued services. Each of the discharge summaries were discussed during the exit conference with the youth, parent/guardian, and juvenile probation officer. All parties who attended the conference, signed the form. The youth's parent/guardian signed the discharge plan the day the youth was discharged from the program; however, the juvenile probation officer did not receive a copy of the discharge plan in two of the three records.

3.08 Specialized Treatment Services (Critical)	**Satisfactory Compliance**
Specialized treatment services shall be provided in programs designated as "Specialized Treatment Services Programs" or are designated to provide "Specialized Treatment Overlay Services.".	

The program has a policy and procedures outlining the provision of mental health overlay services (MHOS) to each youth in the program. The program's specialized treatment services include individual, family, and group therapy sessions. Each therapist was assigned ten youth on their case load. The program director confirmed the program provides MHOS to youth in the program. Mental health groups are held five days a week, substance abuse groups two days a week, and individual counseling sessions twice a month. The licensed clinical professional, who is also the designated mental health clinical authority (DMHCA), is on-site a minimum of forty hours a week and is on-call for consultation twenty-four hours a day, seven days a week.

3.09 Psychiatric Services (Critical)	**Satisfactory Compliance**
Psychiatric services include psychiatric evaluation, psychiatric consultation, medication management, and medical supportive counseling provided to youth with a diagnosed DSM-IV-TR or DSM-5 mental disorder and each youth receiving psychotropic medication in the program as set forth in Rule 63N-1, F.A.C.	

The program has a policy and procedures regarding psychiatric services provided to youth while in the program. The psychiatrist has a clear and active license in the State of Florida, with an expiration date of January 31, 2020. A review of the visitor log for the past six months confirmed the psychiatrist was on-site every week during this annual compliance review period for at least four hours a week and is available for emergencies and consultation twenty-four hours a day,

seven days a week. The psychiatrist, designated mental health clinician authority (DMHCA), and nursing staff meet weekly to discuss and review each youth receiving psychotropic services and their progress. The DMHCA confirmed the clinical staff meets with the psychiatrist weekly to discuss youth receiving psychiatric services. The psychiatrist was interviewed and reported being on-site every Wednesday to see youth. The psychiatrist reported a psychiatric evaluation is completed for each youth upon admission to the program. Youth requiring psychotropic medication are reviewed in a meeting with the DMHCA, case manager, nurse, and psychiatrist every four weeks.

Five youth records were reviewed and three were applicable for psychotropic medications and services. One of the three was applicable for being admitted to the program on psychotropic medications; therefore, the program provided the only additional applicable record for review. Both youth entering the program with psychotropic medications received an initial diagnostic interview within fourteen days of admission. The remaining two youth were prescribed psychotropic medications while at the program and were found to have a completed initial diagnostic interview completed within fourteen days of the referral. The initial diagnostic psychiatric interviews included all required elements. All three pages of the Clinical Psychotropic Progress Note (CPPN) were located in each youth record. Each of the four applicable youth had ongoing medication management completed by the psychiatrist monthly. One medication management visit was five days late for one youth. Each medication management review was documented on the CPPN regardless if the medication was continued or changed, and all medications were consented to by the youth’s parent/guardian. Reviewed documentation supported there were no standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications.

3.10 Suicide Prevention Plan (Critical)	**Satisfactory Compliance**
The program follows a suicide prevention plan to safely assess and protect youth with elevated risk of suicide in the least restrictive means possible, in accordance with the Rule 63N-1, Florida Administrative Code.	

The program has a policy and procedures to include suicide prevention, intervention, and training. The plan was signed February 1, 2019 by the program director and designated mental health clinician authority (DMHCA). The plan was last signed on June 14, 2018 by both the program director and DMHCA. The plan addresses identification and assessment of youth, staff training of at least six hours, suicide precaution (precautionary observation and secure observation), levels of supervision (one-to-one supervision, constant supervision, and close supervision), as well as the referral process, communication, notification, documentation, immediate staff response, and review process.

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

The program has a policy and procedures regarding suicide prevention services for youth. The program does not utilize secure observation. The suicide prevention plan and an interview with the program director confirmed the program director has a process in place to review all serious suicide attempts or incidents of self-injurious behavior. Two of the five youth records reviewed were applicable for receiving suicide prevention services. The program provided one additional youth record for review of suicide prevention services. All three youth were placed on precautionary observation (PO), constant supervision, upon admission. The placement was authorized, and mental health staff provided support services for all three youth. Each youth record reflected a suicide alert was entered into the Department's Juvenile Justice Information System (JJIS); however, one of the three alerts was entered late. The youth was Baker Acted upon admission on August 23, 2018; however, an alert was not entered into JJIS until October 8, 2018, after the program identified the error in an internal audit review. The remaining applicable alerts were entered, as needed. Suicide precaution observations logs were completed correctly except one, which identified secure observation as the safe housing area and the youth was not placed in secure observation. All three records included referrals for further assessment. An Assessment of Suicide Risk (ASR) was conducted the same day as each youth's placement on PO. The ASRs were completed by the licensed mental health staff in each case. All three of the ASRs recommended placement on constant supervision. None of the ASRs required a follow-up ASR. A review of the log books found each incident of PO was documented with the time the youth went on precautions and the time they were placed on close supervision, then returned to standard supervision. All licensed and non-licensed clinical staff completed the twenty hours of ASR training. All youth remained on precautions until a conference was held with the program director and licensed mental health professional who agreed with a reduced level of supervision. The parents/guardians and juvenile probation officers were notified of each youth's potential suicide risk. Five staff were interviewed and each reported when a youth expresses suicide ideations, staff are responsible for notifying mental health, placing the youth on constant sight and sound supervision, documenting supervision, and contacting management. In addition, the staff reported the suicide response kit is located on the dorm and 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.	

Five youth records were reviewed and two were applicable for youth being placed on precautionary observation during the annual compliance review period. The program provided one additional youth records for review of PO logs. Each of the logs were maintained for the duration the youth was on PO. The staff observations of the youth's behavior were documented in real time, at intervals not exceeding thirty minutes. None of the youth displayed any warning signs while on PO. Each PO log was signed by the licensed clinical staff daily. Three youth were interviewed on their experience while being on PO and each youth reported staff were watching them at all times and they were never left alone.

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

The program has a policy regarding suicide prevention training for staff. Five pre-service and in-service staff training records were reviewed. Each of the five pre-service staff completed all required suicide prevention training. Two of the five in-service staff completed all instructor-led and e-learning courses in suicide prevention. Two of the five staff did not complete suicide prevention part I and three of the five staff did not complete suicide prevention part II in the Department's Learning Management System (SkillPro). A review of mock suicide drills for the past year was conducted. There was a mock suicide drill completed on each shift, on each quarter. The drills included the use of the suicide response kit and/or cardiopulmonary resuscitation (CPR)/automated external defibrillator (AED) usage. All current staff, except one, participated in at least two suicide mock drills in the last year.

3.14 Mental Health Crisis Intervention Services (Critical)	Satisfactory Compliance
Every program shall respond to youth in crisis in the least restrictive means possible to protect the safety of the youth and others, while maintaining control and safety of the facility. The program shall be able to differentiate a youth who has an acute emotional problem or serious psychological distress from one who requires emergency services. A youth in crisis does not pose an imminent threat of harm to himself/herself or others which would require suicide precautions or emergency treatment.	

The program has a policy and procedures regarding mental health crisis intervention services. The plan was signed February 1, 2019 by the program director and designated mental health clinician authority (DMHCA). The plan was last signed on June 14, 2018 by both the program director and DMHCA. The plan addresses identification and assessment of youth, staff training of suicide prevention of at least six hours, suicide precaution (precautionary observation and secure observation), levels of supervision (one-to-one supervision, constant supervision, and close supervision), as well as the referral process, communication, notification, documentation, immediate staff response, and review process.

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

The program has a policy and procedures regarding the crisis assessment process for youth in need. The program had one crisis assessment during the annual compliance review period. The crisis assessment was completed at the time of the incident. The assessment reflected the youth was Baker Acted upon admission on August 23, 2018; however, an alert was not entered into the Department's Juvenile Justice Information System (JJIS) until October 8, 2018, after the program identified the error in an internal audit review. The remaining applicable alerts were entered, as needed. The licensed clinical staff completed the crisis assessment and used Department form MHSA 023 for documentation. The youth's parent/guardian and juvenile probation officer were notified of the incident. The youth was placed on constant supervision until Baker Act. When the youth returned to the program, the youth was placed on supervision until follow up examination was completed by the licensed clinical staff and the off-site assessments were reviewed.

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

The program has a policy and procedures regarding the process for emergency mental health and substance abuse services. The plan was signed February 1, 2019 by the program director and designated mental health clinician authority (DMHCA). The plan was last signed on June 14, 2018 by both the program director and DMHCA. The plan included immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Ch.394 (Baker Act), transport for emergency substance abuse assessment and treatment under Ch. 397 (Marchman Act), documentation, training, and review. The program has identified the Circle of Care in Brevard County as the crisis stabilization unit to be used for Baker Act proceedings.

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 has a policy and procedures regarding youth who require Baker or Marchman Act services while in the program. One of the five reviewed youth records was applicable for Baker Act services; therefore, the program was able to provide one additional record for review. When each youth was identified to be in need of Baker Act services, one youth was placed on constant supervision and the other on one-to one supervision. The clinical staff was involved in both incidents until youth were taken off-site due to Baker Act. When both youth returned to the program, they were placed on constant supervision. The licensed clinical staff conducted the Mental Health Status Examination (MSE). The licensed clinical staff conducted the Assessment Suicide Risk (ASR). Both youth remained on precautions until a conference was held with the program director and licensed mental health professional who agreed with a reduced level of 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 has a contract with a licensed physician who holds an unrestricted license, which expires January 31, 2020, and meets all requirements for independent and unsupervised practice in Florida. The physician, who also serves as the program's psychiatrist acts as the designated health authority (DHA). The program has an advanced registered nurse practitioner (ARNP) who has a collaborative practice protocol in place stating the physician is serving as the facility's DHA; however, the ARNP serves as coverage when the DHA is absent or on vacation. The ARNP holds an unrestricted license to practice in Florida, which expires on July 31, 2020. The DHA was on-site at least once a week for the last six months which were documented on the visitor sign in and out sheets. The DHA is available twenty-four hours a day, seven days a week by telephone and is responsible for the communication with program staff regarding each youth's medical needs. The program also has a licensed practical nurse (LPN) and a registered nurse (RN), both of which hold active licenses in the State of Florida, expiring July 31, 2019 and April 30, 2019. An interview with the DHA indicated the DHA is on-site every Wednesday and relies on the nurses to provide updates and information needed, as well as reviewing each youth's records. The DHA is very involved in the monthly meetings and provides treatment according to all information obtained, reviewing charts and logs concerning changes in medical status to determine the needs for each youth.

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

The designated health authority (DHA) and the program director (PD) signed and dated each of the facility operating procedures (FOPs). The DHA signed all nursing protocols originally and each time there was a change made. The PD signed the FOPs on February 7, 2019 during the annual compliance review. All nurses signed and dated a cover page on which all FOPs were listed, acknowledging a review had been completed. An annual review of the FOPs was acknowledged by signatures and dates on January 30, 2019 by the nurses and the PD, the DHA signed the FOPs with the incorrect date of January 2, 2019, and the forms were updated during the review to reflect a signature date of February 1, 2019. One nurse was hired since the last annual compliance review and received training on the policies and procedures, as well as on-the-job training provided by the licensed practical nurse (LPN).

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

Five youth individual healthcare records (IHCRs) were reviewed and each included a legible copy of the Authority for Evaluation and Treatment (AET) with the word "COPY" stamped on the forms. The AET is valid for as long as the youth is under any type of supervision, custody, or other form of legal control by the Department, and/or until the youth's eighteenth birthday. Parental notifications were maintained behind the AET in the IHCR in chronological order.

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

Five youth Individual Healthcare Records (IHCRs) were reviewed and each was applicable for parental notifications for medical treatment. One of the five records were applicable for discontinuation of medication prescribed prior to the youth entering the custody of the Department. Two records were applicable for off-site emergency care notification made by telephone and subsequently in writing. One youth was applicable for off-site medical treatment. Four youth were applicable for receiving new medication. None of the five youth were applicable for parental notification for over-the-counter (OTC) medications not covered by the Authority of Evaluation and Treatment (AET), vaccinations/immunizations not consented for on the AET, significant changes to non-psychotropic medications, changes in condition/medication for youth with chronic conditions, for hospitalizations, surgeries/invasive procedures, and non-routine dental procedures. For each instance which required parental notification, the notification was mailed to the parents and verbal attempts to notify the parent/guardian, if applicable, was documented in the progress notes. In each notification which required telephonic notification, a staff member witnessed all telephone call attempts and conversations. Documentation of telephone notification, verbal consent of the parent/guardian, and staff witness to the notification was documented in the youth's IHCR.

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

Five youth Individual Healthcare Records (IHCRs) were reviewed and three were applicable for psychotropic medication. Each time a medication was prescribed or changed the parent/guardian notifications were made and consent was obtained. Notifications were also sent to the parent/guardian along with the Clinical Psychotropic Progress Note (CPPN) page three when a new psychotropic medication was initiated. The verbal attempts to obtain consent were witnessed by another staff member and documented on the CPPN. Only one of the CPPNs was returned with the parent/guardian signature.

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

Five youth Individual Healthcare Records (IHCRs) were reviewed and each included verification of the youth's vaccinations within thirty days of the youth's admission to the program. The nursing staff indicated immunization records are obtained from the case manager and if unable to locate certain immunizations, the medical staff utilizes Florida Shots for reference. None of the parent/guardians refused consent for needed immunizations for religious or medical reasons.

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

Five youth Individual Healthcare Records (IHCRs) were reviewed and each included the Facility Entry Physical Health Screening Form (FEPHS) which was completed on the date of admission by either a registered nurse (RN) or a licensed practical nurse (LPN).

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

Five youth Individual Healthcare Records (IHCRs) were reviewed. Three youth were taking psychotropic medications and one was admitted with a chronic medical condition. Two additional records were requested for youth with chronic conditions. The nursing staff verified all alerts were accurate and up-to-date. The medical alerts documented in the Department's Juvenile Justice Information System (JJIS) matched the program's internal alert system. Five staff were interviewed and each stated they reviewed the internal alert log to be informed on youth alerts. Two staff also stated they review logbooks and one staff stated they are informed during shift debriefings.

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

The program has a written facility operating procedure (FOP) regarding youth orientation to healthcare services. Five youth Individual Healthcare Records (IHCRs) were reviewed and each reflected the youth received health care orientation upon admission to the program. The healthcare topics included access to medical care, sick call, what constitutes an emergency and when to notify staff, medication process to include side effects monitoring, the right to refuse care and how it is documented, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the health care providers.

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

The program has a written facility operating procedure (FOP) regarding the designated health authority (DHA) admission notification which states the DHA shall be notified within twelve hours of admission of any youth with a chronic medical condition. Five youth Individual Healthcare Records (IHCRs) were reviewed and one youth had a chronic condition but was not in need of an emergency response. In all five IHCRs, the DHA and designated mental health clinician authority (DMHCA) were notified by telephone of the youth's admission, regardless of mental health or medical issues.

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

Five youth Individual Healthcare Records (IHCRs) were reviewed and three were applicable for youth leaving the custody of the program which required a health care admission rescreening. In each of the three applicable IHCRs the youth received a Facility Entry Physical Health Screening (FEPHS), which was completed upon readmission into the program by a licensed medical staff.

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

Five youth Individual Healthcare Records (IHCRs) were reviewed and each included a new health-related history (HRH) completed on the day of the youth's admission by a licensed nurse and done prior to the completion of the Comprehensive Physical Assessment (CPA). Each HRH was reviewed by the advanced registered nurse practitioner (ARNP) as evidenced by a check mark next to "HRH reviewed" on the CPA.

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

The program has a written facility operating procedure (FOP) regarding completion of the Comprehensive Physical Assessment (CPA). Five youth Individual Healthcare Records (IHCRs) were reviewed and in each record a current CPA was maintained, documented the CPA on the Department's form, and completed by the advanced registered nurse practitioner (ARNP). The CPA was completed in accordance with the health service manual requirements including the appropriate medical grade for each youth and all sections marked with an "O" if completed. In the event the youth refused part of the exam, the item was marked with an "X", the youth signed the form acknowledging refusal, and the word "refused" was documented on the form. The Department's problem list was updated where applicable.

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

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

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

The program has a written facility operating procedure (FOP) regarding tuberculosis (TB) screening which is in compliance with the Center for Disease Control (CDC) and the Occupational Safety and Health Administration (OSHA) occupational safety and health

standards. Five youth individual healthcare records (IHCRs) were reviewed and each contained a tuberculosis screening test (TST) conducted within the last year. The results were documented on the comprehensive physical assessment (CPA) and Infectious Communicable Disease (ICD) forms.

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

Five youth Individual Healthcare Records (IHCRs) were reviewed and each were clinically screened and evaluated for sexually transmitted infections (STI). Each youth was tested on the day of admission and the results were documented on the Infectious Communicable Disease (ICD) form as well as the tests being filed in the lab section of the record.

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

Five youth Individual Healthcare Records (IHCRs) were reviewed and each included a form signed by the youth which indicated the youth was offered Human Immunodeficiency Virus (HIV) counseling, testing and possible treatment. Two of the youth consented to HIV testing and the results were filed in a confidential manner consistent with Florida Statute 381.004, within a sealed envelope marked “Confidential” maintained in each youth’s IHCR. The pre-test and post-test HIV counseling was documented on the youth’s Individual Health Education Record. The program does not document the youth’s HIV status in the internal alert system. None of the youth signed a release of information to any other individuals. The provider has two staff who are trained and certified in the HIV/AIDS 500/501 course, as well as in phlebotomy. The staff conducted the counseling, as well as the testing. Five youth were interviewed and each stated they could ask for HIV testing if they wanted to.

4.18 Sick Call Process – Requests/Complaints	Satisfactory Compliance
All youth in the facility shall be able to make Sick Call requests and have their complaints treated appropriately through the Sick Call system.	

The program has a written facility operating procedure (FOP) regarding the sick call process including when the licensed nurse is not on-site. The manager on duty will review the sick call requests to determine if there is an immediate need, this should occur no later than four hours after submission by the youth. The non-healthcare staff will complete the report of on-site non-licensed staff for each youth. The completed sick call request forms will be kept in the sick call box and picked up by the nurse daily. A tour of the program was conducted and it was noted the sick call hours were posted on the door of the nurse’s office at 7:30 a.m. and noon, as well as Saturday and Sunday, as needed. The contract specified sick call to be available four times a week. Two locked sick call boxes were observed, one on the door of the clinic and another in the dining hall.

Five youth Individual Healthcare Records (IHCRs) were reviewed and none were applicable for a sick call during the annual compliance review. Three of the youth had a sick call event on the sick call referral log; however, they were Protective Action Response (PAR) events and not

actual sick calls. The nursing staff indicated they will correct the error and place PAR events on the episodic/first aid referral log. The program was able to provide two youth records applicable for sick call events. Both of the applicable youth records had completed sick call request forms filed with the progress notes in the IHCR and the events were documented on the program's sick call referral log. None of the youth presented the same sick call complaints three or more times within a two-week period or complaint of severe pain with which staff was unfamiliar.

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

Five youth were reviewed and none were applicable for a sick call encounter. The program was able to provide two youth Individual Healthcare Records (IHCRs) applicable for sick call events during the annual compliance review. In both IHCRs the sick calls were documented on the sick call referral log and conducted by a registered nurse (RN). The sick call forms were documented in accordance with the Health Service Rule in the chronological progress notes, signed by the youth at the time of the sick call and filed in the IHCR in reverse chronological order. A sick call was not able to be observed as none were conducted during the annual compliance review. Five staff were interviewed and each indicated the nurse conducts sick call.

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

The program does not utilize restricted housing; therefore, this indicator is rates as non-applicable.

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

Five youth Individual Healthcare Records (IHCRs) were reviewed and three were applicable for receiving episodic care. The documentation of each episodic care event included the date/time of the episodic care, nature of the complaint, findings of person rendering care, treatment rendered, referral to off-site care where needed, parental notification made, and printed name of staff providing care. Two youth received care from non-healthcare staff and each had a documented follow-up by a licensed healthcare staff. In one record the youth refused treatment and the form indicated the event occurred September 10, 2018; however, the event occurred on September 9, 2018. The program corrected the error during the annual compliance review. The program maintains four first aid kits. A first aid kit is maintained for each of the two vehicles in master control, one in the classroom hallway, and another in the medical clinic. All the first aid kits were checked for the approved contents. Each first aid kit was stocked with sterile gauze, a roll of adhesive tape, gloves, band aids, a one-way cardiopulmonary resuscitation (CPR) barrier mask, a biohazard waste disposal bag, aromatic spirits of ammonia, bandages, safety scissors, and antibacterial hand wash. The dates on the applicable supplies were valid and not past the contents expiration date. The nurse provided copies of the last six monthly first aid kit inventories. The program has two knife-for-life and wire cutters, as well as two automated external defibrillators (AED) located with the first aid kits in the clinic and the classroom hallway.

The episodic care events reviewed in the five IHCRs were documented in the last six months of the episodic care log.

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

The program has written facility operating procedures (FOPs) outlining the emergency care procedures. A review of medical drills indicated the program conducted mock emergency drills at least once a quarter on each shift during the annual compliance review which included cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED) demonstration. The review of five staff in-service and pre-service training records indicated first aid, and CPR with AED training were completed. Both nurses also completed CPR with AED, as well as epinephrine auto injector training. A list of the direct care staff trained in the administration of the epinephrine auto injector and training documentation was provided. Emergency numbers are posted in the clinic and are inaccessible to youth including the statewide poison information center. The program has two AEDs on-site, one is located in the classroom hallway and the other in the dorm. The AED procedures are maintained with each AED. The medical staff conduct weekly checks to ensure the AED batteries and pads are operable. A review of the AED checklist reflected the AED located in the classroom hallway and the dorm were checked by the licensed practical nurse (LPN) or registered nurse (RN) on a weekly basis for the past seven months. The pads attached to the AED located in the dorm had an expiration date of February 2021 and the battery was valid until January 2024. The pads attached to the AED located in the classroom hallway had an expiration date of April 30, 2020 and the battery was valid until June 30, 2023. A check of each AED conducted by the nurse found each device operational. The AED located in the classroom hallway was received by the program in August 2018. The dorm AED battery was last changed in July 2018 and the pads was changed in November 2018. Five staff were interviewed and each indicated they are permitted to call 9-1-1 when a youth is identified with a medical emergency.

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

Five youth Individual Healthcare Records (IHCRs) were reviewed and one was applicable for off-site care/referrals. Two additional records were requested and reviewed. The three applicable records had off-site care events documented in the IHCRs. In those events parental notification was completed and documented, the summary of off-site care form was utilized and filed in the youth's IHCR. Discharge information and other documentation was maintained in the IHCR and the designated health authority (DHA) or the advanced registered nurse practitioner (ARNP) reviewed and signed all off-site care findings, instructions and information. In two of the three IHCRs, the youth was in need of follow-up care appointments which were tracked in the progress notes. The youth received the follow up appointment.

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

Five youth Individual Healthcare Records (IHCRs) were reviewed and one documented the youth had a chronic illness. Two additional records were requested and reviewed. The three applicable records had a chronic illness for each youth which was identified on the Facility Entry Physical Health Screening (FEPHS) form. The youth were classified with the appropriate medical grade and placed on a chronic illness list/periodic evaluation tracker. Each youth's IHCR reflected the youth received a specialized treatment plan and periodic evaluations every three months. The evaluations were conducted on-site, documented in the IHCR progress notes, and the Department's problem list was updated, where applicable. An interviewed with the designated health authority (DHA) revealed the DHA tracks the periodic evaluations through a tracking record, as well as updated by the nurses. An interview with the program director (PD) reported the nursing staff has a medical alert roster in place identifying each youth's important medical issues. A medical alert log is sent out daily to staff so everyone is aware of chronic medical issues or updated scheduled appointments. Alerts are discussed in weekly management meetings and sent by secure email.

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

Five youth Individual Healthcare Records (IHCRs) were reviewed and two were admitted to the program with prescription medication. An additional record was requested and reviewed. The three applicable records documented the medication was verified prior to the youth's admission into the program and noted in the chronological progress notes of the IHCR. The nurse notified the designated health authority (DHA) or advanced registered nurse practitioner (ARNP) at the time of the youth's admission and instructions were given for the youth to resume the medications. The nursing staff indicated nurses are always on duty when a youth is being admitted; therefore, non-healthcare staff does not need to verify medications.

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

Five youth Individual Healthcare Records (IHCRs) were reviewed and four were applicable for receiving medications while in the program. In the four applicable records each youth received all medications according to a current, valid order and pursuant to a current prescription. In each record the designated health authority (DHA) or designee included an order in the progress notes indicating when the medications should be started, discontinued, or continued.

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

The program has a written facility operating procedure (FOP) regarding the process for disposal and destruction of expired and/or discontinued medications. All medications on-site are stored in

securely locked areas, inaccessible to youth. The medication cart is located in master control and the remaining stock medications and sharps were located in the medical clinic. The non-controlled medications and over-the-counter (OTC) medications were located in the locked medication cart. All controlled medications and narcotics are maintained in a smaller locked box inside of the medication cart, securely stored behind two locks. The medication cart was clean and organized with labels and dividers for each youth's medications. All oral medications are stored separately from topical medications in the medication cart and in the medical clinic. The medical clinic has a cabinet with separate shelves for oral medications and topical medications. The program does not currently have injectable medications. A separate refrigerator is located in the medical clinic for medications which require refrigeration. A log is maintained in the medical clinic documenting a daily check of the refrigerator temperature, which reflected checks from November 2018 to the current date. The syringes and sharps are secured in a locked cabinet inside the medical clinic. The stocked items are maintained in the medical clinic separate from the youth's specific medications.

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

The program has a written facility operating procedure (FOP) which includes the procedures for narcotics and other controlled substance inventories, as well as reporting criteria and procedures for inventory discrepancies. The program maintains a weekly and perpetual inventory of all over-the-counter (OTC) medications. A shift to shift count of controlled medications are conducted with two staff signatures. A perpetual inventory with running balances is also maintained for the controlled medications. A random count of three controlled medications, three youth medications, and three sharps conducted by the nurse found the counts to be accurate when matched to their inventory. The last six months of sharps inventories were reviewed. There were no discrepancies noted.

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

The program has a written facility operating procedure (FOP) regarding controlled medication inventory which includes the shift-to-shift inventory counts. The program conducts shift to shift counts of controlled medications with two staff signatures. All controlled medications and narcotics are maintained in a small locked box inside of the medication cart, securely stored behind two locks. A random count of three controlled medications conducted by the nurse found the counts to be accurate when matched to the inventory. A review of three controlled medication storage inventory forms for the last six months was conducted, a shift-to-shift count was completed and documented on the form. There were no discrepancies noted.

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

Five youth Individual Healthcare Records (IHCRs) were reviewed and four were applicable for receiving medications while in the program. The four applicable records documented the youth

were receiving medications and the pre-printed Medication Administration Records (MAR) were utilized. The MAR indicated the youth received the medications as ordered and staff initialed each entry on the MAR. The MAR contained the youth's name, Department of Juvenile Justice Identification (DJJID), date of birth (DOB), youth allergies, precautions, and medical grade. The program had a separate binder located with the medication cart for the most current MARs. The binder contained a sheet prior to each youth's MAR with the youth's picture on the form and demographics. Two of the youth were taking medications during their admission and the initial MAR matched the medication list. In all four IHCRs, the youth received the medications as ordered. The MAR indicated the start and stop dates and weekly side effect monitoring was documented. There were no instances of missed psychotropic medications.

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

The program has a written facility operating procedure (FOP) regarding medication administration by licensed staff. A medication pass was observed for three youth. The licensed nurse administered the medications and the nurse's work space was clean and organized. The nurse had control of the medications and the medication cart. Each youth stated what medications they were taking prior to administration. None of the medications were pre-poured, no refusals occurred, and the nurse ensured the medication was swallowed. None of the youth were applicable for receiving parenteral medications during the annual compliance review . Five youth were interviewed and three youth indicated the nurse provides medication, but if not on-site a trained staff member is allowed to assist with medication self-administration. The remaining two youth stated they do not take medications.

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

The program has a written facility operating procedure (FOP) regarding medication administration by non-health care staff. Five youth Individual Healthcare Records (IHCRs) were reviewed and two were applicable for medication administered by a non-licensed healthcare staff. The staff and youth both initialed the Medication Administration Record (MAR). The staff is trained in medication self-administration. Five staff were interviewed and each indicated the nurses provide medications. Three staff stated medication may be provided by trained staff. Five youth were interviewed and three youth indicated the nurse provides medication, but if not on-site a trained staff member is allowed to assist with medication self-administration. The remaining two youth stated they do not take medications.

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

The program has a written facility operating procedure (FOP) regarding the process for monitoring youth on psychotropic medications to ensure the youth's safety. Five youth Individual Healthcare Records (IHCRs) were reviewed and one was applicable for being admitted to the program with psychotropic medications. The program had one additional youth admitted with psychotropic medication during the annual compliance review period and provided the record for review. In the two applicable records, the designated health authority (DHA) and designated mental health clinician authority (DMHCA) were notified of the youth's admission and the psychotropic medication was continued until a psychiatric interview was conducted. The initial psychiatric interview and psychiatric evaluation was conducted within fourteen days of the youth's admission. The youth received medication monitoring by the program's psychiatrist, monthly. Each youth admitted to the program receives a psychiatric evaluation within thirty days of admission. The psychiatric evaluation is documented on a program form and on the Clinical Psychotropic Progress Note (CPPN) page three, if the youth is receiving psychotropic medication. The psychiatric evaluation includes the diagnosis, target symptoms of each medication, evaluation and description of effect of prescribed medication on target symptoms, prescribed medication name, dosage, and quantity, side effects, youth's adherence to the medication regimen, weight, telephone contact with parent/guardian to discuss medication, the signature of the psychiatrist and date of the signature, as well as where appropriate the monthly Tardive Dyskinesia monitoring. The program indicated the date of the psychiatric evaluations and the signature on the evaluations may be several days apart due to the psychiatrist dictating the evaluation and signing the evaluation when on-site. The program does not have any standing orders, emergency treatment orders, and as needed/pro re nata (PRN) orders for psychotropic medications.

4.34 Infection Control – Surveillance, Screening, and Management	Satisfactory Compliance
The facility shall have implemented Infection Control procedures including prevention, containment, treatment, and reporting requirements related to infectious diseases, as per OSHA federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines.	

The program has a written facility operating procedure (FOP) including prevention, containment, treatment, and reporting requirements related to infectious diseases. The infection control procedures included common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis (TB), hepatitis A, B, C and human immunodeficiency virus (HIV) infectious diseases caused by blood-borne pathogens, other outbreaks or epidemics caused by any other infectious agent, outbreaks of pediculosis and/or scabies, methicillin-resistant staphylococcus aureus (MRSA) and other emerging antibiotic-resistant micro-organisms, food-borne illnesses such as those caused by Escherichia Coli, bio-terrorist agents, chemical exposures in the workplace, hepatitis B immunizations available for staff, staff having access to protective equipment, and staff adhering to universal precautions. The program indicated they did not have instances in which the local county health department, the Communicable Disease Center (CDC), and/or the Department's Central Communications Center (CCC) required notification of an infectious disease.

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

Five youth Individual Healthcare Records (IHCRs) were reviewed and each documented the youth received training in prevention of communicable disease and prevention of bloodborne pathogens. A review of all five staff in-service and five pre-service trainings had documentation infection control/exposure control training was completed.

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

The program has a comprehensive infection control education plan written in accordance with the Occupational Safety and Health Administration (OSHA) standards, including pre-service and in-service training for all staff, risk assessment and methods of compliance, comprehensive process for needle stick post-exposure evaluation, and youth infection control education, as required by the Center for Disease Control (CDC) guidelines. The plan was reviewed and signed by the program director (PD) on January 30, 2019. The program indicated they did not have instances of facility/occupational exposures, three or more infectious diseases outbreaks, and/or ten percent or more of staff/youth having a contagious disease. An interview with the PD indicated the exposure control plans are located in a binder in the staff's station on the medical cart and another in the nurse's station/office. The plan is reviewed with staff in the monthly staff meetings.

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

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

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

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

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

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

Standard 5: Safety and Security

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

The program has a written policy and procedures to provide for staff supervision. The review annual compliance team observed supervision throughout the review during youth movement, large group meeting/graduation ceremony, class room activity, meal routine, clean-up routine, outside recreation, breaks, and searches. Staff to youth ratio was usually within the contract requirement of one staff to eight youth; however, staff were observed out of ratio on three occasions. On Tuesday afternoon, a review team member observed youth movement in which the ratio was one staff to ten youth. On Wednesday during class time, a review team member observed nine youth in the classroom with one school board teacher and no program staff. The youth were then moved outside the classroom and lined up where it was observed there was one staff to thirteen youth for four to five minutes until a second staff came to assist in movement to the recreation field and bathroom breaks. On Thursday, a review team member observed three staff with twenty-six youth. Informal staff interviews revealed staff were aware of the number of youth they were supervising. Staff indicated they would notify the supervisor if a youth was missing and stop movement. The review team observed staff positioning throughout the week. Staff were consistently positioned at the perimeter of spaces and/or on opposite sides of the space when two staff were present. Staff were engaged in appropriate language and manners during discussions with youth.

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

The program has a written policy and procedures to provide for a comprehensive and consistent implementation of the behavior management system (BMS) and staff training. The procedures include a token economy with positive incentives and concrete consequences including oversight by management. The BMS specifically prohibits disciplinary confinement, temporary placement in secure observation, behavior management unit, the use of mechanical restraints as a disciplinary punishment, the use of any type of restraint chair, securing youth to a fixed object, binding the youth’s hands to their feet, or the use of any other mechanical restraint method. The procedures also include requirements for staff training in the BMS. Monitoring of the BMS includes staff feedback at all team meetings, opportunities to address unique problems in providing positive ways to problem solve and encourage youth, and feedback on individual staff evaluations on the use of the behavior management system. A copy of the BMS was found posted to the wall inside the dormitory during a tour of the program. The BMS is also written in the youth handbook which includes the length of stay and the six levels (orientation,

commitment, change 1, change 2, maintenance, and transition). The system utilizes incentives to positively reinforce behavior with a five-to-one ratio of positive to negative reinforcement. The incentives include basketball tournaments, special off-campus events, student council, honor resident's placement in the four-bunk room, "man-cave" privileges including play station and electronic music listening devices, campus parties, movie nights, fun Fridays, birthday celebrations, positive pull-ups from staff and peers, lunch with the director, participation in the point store process, and awards given at the bi-weekly assembly. There are two means for documenting negative behaviors which includes a minor where youth are placed in study hall, and a major in which the behavior is documented on a problem behavior report with five classes of violations and a behavior contract. Behavior contracts are classified into three types such as three, five, and seven-day contracts.

The program provided a copy of the collaborative agreement with the school board on the BMS dated, October 18, 2018. Staff interviews indicated the program and the school board collectively negotiated the agreement incorporating the teacher's participation and support into the BMS. The agreement enabled teachers to write problem behavior reports for misbehaving youth which are processed by the program administration. Teacher interviews indicated they feel supported by program staff in managing misbehaving youth in the classroom. Informal interviews with teaching staff indicated they were trained on the BMS many years ago, but the BMS has changed several times since then. Five pre-service and five in-service staff training records were reviewed and each documented completion of training in the BMS.

5.03 Behavior Management System Infractions and System Monitoring	**Satisfactory Compliance**
The program's behavior management system (BMS) is designed to maintain order and security, provide constructive discipline and a system of positive and negative consequences to encourage youth to meet expectations for behavior, provide opportunities for positive reinforcement and recognition for accomplishments and positive behaviors, promote dialogue and peaceful conflict resolution, and minimize separation of youth from the general population. *Supervisors shall monitor staff implementation of the behavior management system (BMS), and ensure the use of rewards and consequences are administered fairly and consistently in application among all staff.*	

The program has a written policy and procedures to provide for behavior management system (BMS) infractions and system monitoring. An interview with the program director (PD) revealed the BMS and consequences are monitored by the PD. The program utilizes problem behavior reports (PBR) to identify negative behaviors and the consequences for each infraction which are already established based on the infraction. Five staff were interviewed and each was able to explain the program's BMS as based on phases with each phase allowing the youth additional privileges. The staff shared rewards in the program including the opportunity to phase up, receipt of caught being good "bucks" to use in the program "store", incentives such as treats and parties, off-campus activities, meals from off-campus, dinner with the director, and positive peer recognition. One staff indicated the BMS is included in the youth handbook. Two staff indicated the BMS includes defined rewards and consequences. Youth are also allowed to save their "bucks" for redemption at treatment team to phase up early. The interviewed staff described the consequences as being limited to losing a level, behavior contract for a limited time, limited participation in elective activities, and prohibition in participation of campus trips. Each staff reported youth are informed of their consequences and are able to explain their behaviors by writing on the PBR or explaining their side of the behavior with administration. The various

categories and description of prohibited behaviors are listed on the PBR along with the prescribed consequences informing each youth what the protocol indicates. A review of four applicable staff personnel records found three of the four staff performance evaluations were recorded on new forms which do not specify the staff's adherence to and use of the BMS; however, the evaluation covers adherence to policy and procedure. The five interviewed staff reported they are provided feedback regarding their use of the BMS, including discussion during in-house meetings and staff meetings, addressing issues/concerns with individual staff through one-on-one conversations and training, and in-the-moment coaching to immediately address any issues.

Five youth were interviewed regarding the BMS. The youth were each able to describe the BMS as including the six levels such as orientation, commitment, change 1, change 2, maintenance, and transition, and youth move between levels based on the number of days and requesting to advance based on progress. One of the five youth clarified the process indicating youth have to be at the program for twenty-one days and fill out packets to move up and can only move up every twenty-one days and take a test. Youth collectively described the consequences as receiving a behavior contract or thirty-day extension, running laps, study hall, stand in the corner if they are being disrespectful, receive a PBR, or could be restrained physically. When asked about being physically restrained as a punishment, youth described this only occurs if they are fighting other youth to separate them. Youth described the rewards as including "bucks" to spend at the point store, free phase up, extra food, off-site activity, video games, candy, drinks, snacks, cakes, ice cream parties, and treats. All five youth indicated youth are not allowed to punish other youth and staff are consistent in the use of rewards. Four of the five youth rated the BMS as good and one youth rated the BMS as very good. The program's policy, youth and staff interviews confirmed the program does not utilize room restriction.

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

The program has a policy and procedures for conducting ten-minute checks when youth are in their sleeping quarters. The review team observed a binder with ten-minute checks filed by the month for each month of the annual compliance review period. The camera system has capacity for fifty-four days of recorded video storage. Video was reviewed for ten-minute checks on January 15, 2019 January 26, 2019 between and January 28, 2019. Reviewed documentation found each paper check sheet for the selected days documented each check was conducted at nine-minute intervals without exception. Observations of the video recording found checks completed on January 15 and January 28 were consistently completed between eight and eleven minutes and were not completed in nine-minute intervals as documented on the paper check sheets. On January 26, the paper check sheets also documented checks as occurring every nine minutes from 2:58 a.m. to 3:30 a.m.; however, video revealed no checks were conducted between 2:55 a.m. and 3:30 a.m. The review team alerted the program of the finding and contacted the Central Communications Center (CCC) for the alleged falsification of ten-minute checks. An additional five days of documented ten-minute check sheets were reviewed, each of the sheets did not appear to be documented in real time as checks were consistently documented at exactly nine-minute intervals. Five staff were interviewed and each reported room checks are conducted when a youth is placed in their room for sleeping or non-

punishment reasons every ten minutes. Further, three staff expanded checks are conducted every nine minutes, every eight to ten minutes, and within ten minutes.

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

The program has a written policy and procedures covering census, counts, and tracking. The program tracks the daily census, new admissions, discharges, transfers, and when youth are temporarily away from the program. Counts were completed as required and consistently documented in the logbook at the beginning and end of the shift with random counts in between. Random counts were documented on most days three to five times per shift. A review of admissions indicated the case manager documented the identifying information relevant to each youth admitted to the program along with any related alerts. All discharges and transfers were also found documented in the logbook. There were no instances found in the logbook or incident reports of an emergency situation during the review period requiring an emergency count; however, there are procedures in place to provide for documentation of a count in case of an emergency. Procedures defined as situations requiring an emergency count are a missing youth, major disturbance, limited visibility, or power failure. During the review a power failure occurred in the administration building; however, all youth and direct care staff were outside at recreation without knowledge of the incident and an emergency count was not taken. Five staff were interviewed and each indicated counts are conducted every thirty minutes, every transition, when youth wake up, and if a discrepancy occurs. When a count cannot be confirmed, all movement is stopped, a count is taken, staff brings all youth to one location, another count is performed, and a search is conducted throughout the campus.

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

The program has policy and procedures in place addressing logbook entries. The program has designated one specific direct care staff to enter documentation in the logbook during the first shift Monday through Friday of each week. This staff is positioned in administration to monitor the camera system and coordinate movement. For other shifts, a shift lead is identified to

conduct the shift change briefing and designates one person responsible for logbook documentation. A review of the three logbooks for the review period revealed all were bound with numbered pages and in good condition. Entries were clearly legible with the times of entry consistently noted. The times of each entry were consistently noted along with the name of the staff making the entry. The name of staff making entries were occasionally unidentifiable. Most corrections were documented according to procedures with a single line through the applicable words; however, the initials of the staff making the correction was inconsistently noted. Counts were consistently documented at the beginning and end of the shift with random counts in between. Youth movement, transports, perimeter checks, and incidents were consistently documented. Some staff highlighted numerous entries, while other shifts had no highlighting, although the situations were consistent with the shifts in which there was highlighting. Incoming staff consistently documented a review of the previous two shifts in all logbook days reviewed and supervisory reviews were documented regularly. All protective action reports (PAR) were documented in the logbook. A review of four calls to the Department's Central Communications Center (CCC) revealed each were documented in the respective 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*	

The program has a written policy and procedures covering key control which includes the control of active, permanent, restricted, transportation vehicle, executive security, file, medical safe, and emergency keys. The program does not utilize a special key for egress as all exit doors do not require a key for exit. A review of the two key lockers revealed one was designated for staff and one for visitors. The staff box had an individual hook labeled for each staff member designated for personal vehicle keys. The second box had individual hooks designated for visitors. Each visitor hook had a detachable tag labeled "visitor" along with a number. The visitor tags had consecutive numbers. During check-in, each review team member surrendered their respective vehicle keys and was issued a numbered visitor tag. In addition, administration issued a visitor door key to the team and required the lead reviewer to sign a form for accepting responsibility for the key. An interview with the program director (PD) revealed only administration, case managers, therapists, teachers, maintenance, and food service staff receive permanent issued key rings. Further, all staff are required to secure their personal keys upon arrival. Additionally, staff without permanent issued keys must secure their keys prior to being issued program keys for their shift. If keys are damaged or broken a work order is submitted with the provider. Two staff keys were checked for compliance with key issuance logs. Each ring reviewed had the number of keys documented on the key ring issue page and each ring was a Morse Security ring. A review of a third staff key ring revealed keys were bound on a permanent key ring with a brass tag indicating four keys. A review of the key ring found four keys on the permanent ring with a detachable ring also on the permanent ring containing two additional keys. Staff interviews revealed the key ring was a permanent issue ring and the two additional keys belonged to file cabinets. Staff later removed the detachable key ring. Five staff were interviewed and indicated key control involves personal keys are securely stored and damaged or missing keys are immediately reported to administration. Four staff indicated

damaged keys are replaced. Two staff indicated personal keys are given to master control upon entry, the program is searched for missing keys, and youth are searched for missing keys. Other responses from individual staff included there is a daily tracking of keys or use of a key log, there is an inventory of keys, and youth do not have access to keys. One staff reported the program goes on lockdown if keys are missing and the Department's Central Communications Center (CCC) is called.

5.08 Contraband Procedure	Satisfactory Compliance
The program shall develop and implement a system to prevent the introduction of contraband into the program. *A residential commitment program shall delineate items and materials considered contraband when found in the possession of youth. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its youth.* *The program shall document the confiscation of any contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the program director or designee has the discretion to discard the item, return it to its original owner, mail it to the youth's home, or return it to the youth upon release. In all instances involving confiscation of illegal contraband, the program shall turn the item over to local law enforcement.*	

The program has a written policy and procedures covering contraband which includes the use of searches and facility searches for contraband, a contraband example list, and procedures for the confiscation and disposal of contraband. The policy also documents procedures for the search of incoming and outgoing mail for contraband. A review of the list of contraband items in the procedures and the youth handbook revealed most listed categories were found. The list provided to youth did not include electronic or vaporless cigarettes, or other tobacco products, cell phones, keys, illegal items, or escape paraphernalia. The list includes illegal substances and illegal drugs, but no other illegal designations. The list was modified during the review to include the missing items. A review of five youth records revealed each youth received a list of the contraband items at admission. Reviewed documentation revealed youth searches are conducted at admission, upon movement from building to building, from classroom to the cafeteria, and following work details and visitation. There was no documentation illegal contraband was found during the review period; however, the program has procedures for disposal of found contraband. The program director was interviewed and revealed outgoing mail is searched by administrative personnel prior to mailing to ensure there is no contraband sent out. Incoming mail is also opened and searched for contraband prior to delivery to the youth. The review team observed staff performing a cursory review of outgoing mail. Visitation rules were posted in the lobby of the administration building including a list of contraband items and a warning of consequences for bringing contraband into a juvenile justice facility. The program maintained a search log for youth returning from visitation including staff performing the search and a witness. In the event contraband is found, the director makes the decision whether to discard the item, send the item home, or return it to the youth upon release. In the event the contraband is discovered to be of an illegal nature, the director will turn over the contraband to the 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.	

The program has a written policy and procedures concerning searches and full body visual searches. Searches are conducted by staff of the same gender when youth return to the campus from a supervised activity away from the program or a home pass, upon completion of supervised work or vocational activities where tools are used, upon youth admission, following a serious security breech, and following visitation. Procedures also include the requirement for facility searches of youth rooms, dormitory, school, common areas, and mail. The review team was unable to observe a full body visual search. The review team observed numerous searches of youth during the review week including transitioning youth from outside to the inside, following recreation, and upon movement from school. Youth were always searched by a male staff. Five staff were interviewed and each indicated youth are searched at every transition or movement. Two staff further indicated searches are done on the outside of clothing while the second staff indicated searches are done when anything is missing and cannot be found. Five youth were interviewed and each indicated searches are conducted when returning from off-campus trips, after outdoor activities, when items are missing, after visitation, after meals, and after work detail. Four youth also indicated searches are conducted after every movement/transition. A fifth youth indicated a search is conducted when a youth is admitted to the program.

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

The program has a facility operating procedure (FOP) regarding the maintenance of program vehicles. The program utilizes two vans to transport youth. An annual safety inspection conducted by a local vendor was found for both vehicles. Observations of the vehicles were conducted with the program director (PD) and both vans were found to have the proper number of seatbelts and a fire extinguisher maintained in the vehicle. Each van appeared to be in good condition. A seat belt cutter, window punch, and first aid kit are kept in a transport bag and available for each van in the transportation key box located in the administration building. An interview with the PD verified the first aid kits are kept in the transportation key box to prevent early wear and tear of materials inside the kit. When not in use, both program vehicles and all employee vehicles were found to be securely locked. A transport was not able to be observed during the annual compliance review.

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

The program has a facility operating procedure (FOP) outlining the process for the transportation of youth in program vehicles. The FOP and an interview with the program director (PD) confirmed the program follows a one staff to five youth ratio for all transports; however, there is always at least two staff on all transports. One staff member occupies the vehicle along with the transporter due to neither program vehicle having a safety screen. The rear doors do not lock from within; therefore, staff ensures proper security and supervision to prevent youth from attempting to open the doors. All staff and youth are required to wear seatbelts during transports, and youth are not attached to any part of the vehicle other than by a seat belt. The PD further asserted youth are not left unsupervised in program vehicles nor allowed to drive program or staff vehicles. Transporters are provided with a radio or cell phone for communication in case of an emergency or vehicle problem. During a random campus walkthrough, it was again confirmed all program and employee vehicles were consistently locked when not in use. A transport was not able to be observed during the annual compliance review; however, staff interviews confirmed staff are given communication devices during transports and staff follow the off-site ratio of one staff to five youth.

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

The program has a facility operating procedure (FOP) which outlines the requirement to conduct weekly safety and security audits. The program utilizes the safety and security audits to identify, track, and repair facility deficiencies through work orders which are attached to the weekly inspection documents. The "Facility Inspection Binder" was reviewed and documented weekly safety inspections were taking place no more than seven days apart. An interview with the program director (PD) verified this practice and confirmed there are no outstanding issues identified by the weekly audits; however, any deficiencies would be identified by submitting a work order, and tracked in the management meetings.

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

The program has a facility operating procedure (FOP) which outlines tool storage and use. The FOP and an interview with the program director (PD) confirmed only class "B" tools, mops, brooms, and scrub brushes, are kept on-site and are securely locked when not in use. There is a picture board in the tool storage areas to identify each tool which should be secured in the area. Observations were conducted with the PD and tools were found to be securely locked in designated areas when not in use. Five youth and five staff training documentation were reviewed and found to have the included training completed in tools. All staff and youth Class "B" tools training documentation is maintained in the "In-House Meeting Binder." The program's FOP clearly outlines a process for missing tools, which includes notifying the program manager and the PD, locking down the program until the item is found, and calling the Department's Central Communications Center (CCC).

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

The program has a facility operating procedure (FOP) which outlines the handling and usage of tools by youth. An interview with the program director (PD) and observations confirmed the program only keeps class B tools on-site. The PD reported staff maintains the contract required ratio of one staff for every five youth when youth are using tools. The program utilizes risk assessments to determine if and when youth are suitable for handling tools in the program, which are kept in a binder. The binder was found to include risk assessments for each of the five reviewed youth. Five pre-service staff and five youth training documentation were reviewed and confirmed each completed training in tool use at the program. Five staff and five youth interviews confirmed youth are only allowed to use mops, brooms, and scrub brushes.

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

The program has a written policy and procedures addressing outside contractors. The program has a form documenting the contractor and tool search. The form documents an inventory of tools was conducted by program staff but does not specify when the inventory was completed. The outside contractor binder included delivery contractors as well as contractors providing estimates and disposal services. Staff documented a review of contractor tools and accompanied contractors during work performance on campus. A review of invoices for completed work found each invoice had a corresponding entry in the outside contractor binder. A review of incident reports did not reveal any contractor tools were missing during the review period.

5.16 Fire, Safety, and Evacuation Drills	Satisfactory Compliance
The program shall conduct fire, safety and evacuation drills to ensure youth and staff are prepared for immediate implementation or mobilization in the event of an emergency or disaster.	

The program has a Continuity of Operations Plan (COOP) which outlines emergency drills frequency to include monthly fire drills, monthly safety drills, and annual evacuation drills. An interview with the program director (PD) verified the frequency of the drills. All required drills were completed during the annual compliance review period. Drill documentation was reviewed and included the type of drill, date of drill and time, participants, a brief scenario of the drill, and findings from each drill. Five youth were interviewed and each reported they have been instructed on what to do in case of a fire and participated in fire drills. Two youth reported fire drills are conducted monthly, two youth reported drills are conducted three times a month, and one youth reported drills are conducted twice a month.

5.17 Disaster and Continuity of Operations Planning	Satisfactory Compliance
The program shall have a coordinated disaster plan and Continuity of Operations Plan (COOP) or one comprehensive plan incorporating both. The plan(s) shall provide for the basic care and custody of youth in the event of an emergency or disaster and continuity of the aforementioned, while ensuring the safety of staff, youth and the public. The plan shall be submitted to the regional director, or designee, for approval and signature.	

The program has a Continuity of Operations Plan (CCOP) which includes all required information and approved by the Department's residential services COOP coordinator on May 2, 2018. The program director was interviewed and reported the COOP is maintained in the administration building and dorm accessible to all staff which was confirmed during a tour of the program.

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

The program has a facility operating procedure (FOP) in place regarding the storage and inventory of flammable, poisonous, and toxic items and materials. An interview with the program director (PD) and observations confirmed there are no flammable, poisonous, or toxic materials stored on campus. Inventories with accurate counts were found for all cleaning materials. Each item is accompanied by the Safety Data Sheets (SDS) posted in the storage areas. An observation of the cleaning materials storage area found the items were securely locked and accounted for accompanied by posted SDS sheets.

5.19 Youth Handling and Supervision for Flammable, Poisonous, and Toxic Items and Materials	Satisfactory Compliance
The program shall maintain strict control of flammable, poisonous, and toxic items and materials. *Youth shall not be permitted to use, handle, or clean dangerous or hazardous chemicals or respond to chemical spills. Youth shall not be permitted to clean, handle, or dispose of any other person's biohazardous material, bodily fluids, or human waste.*	

The program has a facility operating procedure (FOP) in place regarding youth handling of flammable, poisonous, and toxic items and materials. An interview with the program director (PD) and observations confirmed there are no flammable, poisonous, or toxic materials stored on campus. The program's FOP outlines youth use of cleaning chemicals as only wiping or mopping with substances distributed by staff. Youth must be supervised at all times while using the chemicals. During the annual compliance review, youth were observed cleaning under the supervision of staff and not in direct contact with any cleaning chemicals. Five youth were interviewed and each reported they could not handle chemicals and one youth reported they could use laundry detergent and cleaning chemicals but could only utilize them after staff handled and distributed them.

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

The program has a facility operating procedure (FOP) in place regarding the disposal of flammable, poisonous, and toxic items and materials. An interview with the program director (PD) and observations confirmed there are no flammable, poisonous, or toxic materials stored on campus. The PD reported cleaning chemicals are disposed of through the drains in the dorm, kitchen, and administrative building. Any other potentially hazardous waste such as kitchen grease is disposed of by an outside vendor when necessary. During a tour of the program, the locations and containers for hazardous materials such as used cooking oils were identified.

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

The program has a written policy and procedures addressing recreation and leisure. The program has meaningful structured activities seven days a week during awake hours. Youth have the opportunity to attend faith-based services, weekly. The program's contract requires the program to provide therapeutic recreation and a recreation schedule to include afternoon, evenings, and weekends. The recreational activities guided by the recreation therapist should be separate and distinct from mental health and substance abuse treatment services. Five youth records were reviewed and each included a recreation treatment plan. The recreation therapist attends each youth's treatment team and provides updates, as necessary. A recreation schedule was not able to be found for February 2019 during the tour of the program. Interviews with staff revealed there was no current recreation schedule posted. The program provided documentation of activity schedules which were posted for each of the months in the annual compliance review period, except February 2019. Additional documentation was provided and included weekly recreation therapist notes on each youth of activities completed and the youth's level of participation. A comparison of the weekly notes and the schedule for the month revealed the schedules matched the weekly youth activities. All five interviewed staff indicated youth receive at least one hour of recreation time daily and activities include basketball, football, running, four square, cards and inside games, volleyball, relay races, large muscle activities, board games, video games, artwork, cooking club, book club, music/instruments, cards, dominoes, and table tennis. Five youth were interviewed regarding available recreation activities and indicated football, basketball, volleyball, games, ping pong, kickball, four square, board games, and card games were offered. Four of the five youth indicated specifically they received at least one hour of recreation daily, two indicated more than an hour, and one youth indicated they can play anything as long as there is no fighting.

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

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

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

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

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

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

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

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

The program has a written policy and procedures addressing visitation and communication. The program schedules visitation weekly on Sunday afternoons in the administration building. The visitation rules and schedule are provided to the youth and parent/guardian at admission. The program maintains an approved visitor list for each youth accessible to staff supervising visitation. Special visitation is arranged with the designated mental health clinical authority (DMHCA) for families who are unable to arrange visitation on the regularly scheduled day. Youth also have opportunities to write their family weekly and are provided writing materials and postage. Five youth were interviewed and each indicated they had been given the opportunity to communicate with family members by mail, telephone, or at visitation. Informal interviews with youth indicated family members visited youth during the weekend visitation time if they are able and one youth indicated their family lived a considerable distance away and had not been able

to visit him. A review of five youth records revealed each youth was allowed phone contact with their family, weekly.

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

The program does not utilize controlled observations; therefore, this indicator rates as non-applicable.

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

The program does not utilize controlled observations; therefore, this indicator rates as non-applicable.

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

The program does not utilize controlled observations; therefore, this indicator rates as non-applicable.

Program Name: Brevard Group Treatment Home
Provider Name: Aspire Health Partners
Location: Brevard County / Circuit 18
Review Date(s): February 5-8, 2019

MQI Program Code: 571
Contract Number: R2109
Number of Beds: 30
Lead Reviewer Code: 161

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.06 Protective Action Response (PAR) and Physical Intervention Rate	1.01 Initial Background Screening*
1.08 In-Service Training	1.02 Five-Year Rescreening
2.17 Educational Access	5.04 Ten-Minute Checks*
5.01 Youth Supervision	