STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
PROGRAM REPORT FOR

Brooksville Academy
Youth Opportunity Investments, LLC
(Contract Provider)
201 Culbreath Road
Brooksville, Florida 34602

Review Date(s): May 7-10, 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:

Jennifer Schad, Office of Program Accountability, Lead Reviewer (Standard 1)
Phil Amorgianos, Jacksonville Youth Academy, Facility Administrator (Standard 2)
Kelley Brault, Circuit 5 Probation, Senior Juvenile Probation Officer (Interviews)
Renette Crosby, Office of Education, NE Region Education Coordinator (Indicators 2.16-2.18)
Katina Horner, Office of Program Accountability, Regional Monitor (Standard 3)
Amy Hutto, Office of Program Accountability, Regional Monitor (Standard 5)
Ben Marrufo, Office of Program Accountability, Technical Assistance Specialist (SPEP)
Donna Stanton, Cypress Creek Treatment Center, Director of Nursing (Standard 4)

Program Name: Brooksville Academy
Provider Name: Youth Opportunity Investments, LLC
Location: Hernando County / Circuit 5
Review Date(s): May 7-10, 2019

MQI Program Code: 1445
Contract Number: 10208
Number of Beds: 60
Lead Reviewer Code: 143

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
- 1 # Case Managers
- ____ # Clinical Staff
- ____ # Food Service Personnel
- ____ # Healthcare Staff
- 1 # Maintenance Personnel
- 2 # Program Supervisors
- 7 # Staff
- 7 # 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
- 7 # Health Records
- 7 # MH/SA Records
- 7 # Personnel Records
- 7 # Training Records/CORE
- 3 # Youth Records (Closed)
- 7 # 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	Satisfactory
1.02	Five-Year Rescreening	Satisfactory
1.03	* Provision of an Abuse-Free Environment	Satisfactory
1.04	* Management Response to Allegations	Satisfactory
1.05	* Incident Reporting (CCC)	Satisfactory
1.06	Protective Action Response (PAR) and Physical Intervention Rate	Satisfactory
1.07	* Pre-Service/Certification Requirements	Satisfactory
1.08	In-Service Training	Satisfactory
1.09	Grievance Process	Satisfactory
1.10	Delinquency Intervention and Facilitator Training	Satisfactory
1.11	Life Skills Training Provided to Youth	Satisfactory
1.12	Restorative Justice Awareness for Youth	Satisfactory
1.13	Gender-Specific Programming	Satisfactory
1.14	*Internal Alerts System and Alerts (JJIS)	Satisfactory
1.15	Youth Records (Healthcare and Management)	Satisfactory
1.16	Youth Input	Satisfactory
1.17	Advisory Board	Satisfactory
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	* Designated Health Authority/Designee	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification	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	Room Restriction/Controlled Observation	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	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	*Ten Minute Checks	Satisfactory
5.05	Census, Counts, and Tracking	Satisfactory
5.06	Logbook entries and Shift Report Review	Satisfactory
5.07	Key Control	Satisfactory
5.08	Contraband Procedure	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	Vehicals and Maintenance	Satisfactory
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Satisfactory
5.13	Tool Inventory and Mangement	Satisfactory
5.14	Youth Tool Handling and Supervision	Satisfactory
5.15	Outside Contractors	Satisfactory
5.16	Fire, Safety, and Evacuation Drills	Satisfactory
5.17	Disaster and Continuity of Operations Planning (COOP)	Satisfactory
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.19	Youth Handlins and Supervison of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.20	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.21	Recreation and Leisure Activities	Satisfactory
5.22	*Elements of the Water Safety Plan, Staff Training, and Swim Test	Non-Applicable
5.23	Visitation and Communication	Satisfactory
5.24	Search and Inspection of Controlled Observation Room	Non-Applicable
5.25	Controlled Observation	Non-Applicable
5.26	Controlled Observation Safety Checks and Release Procedures	Non-Applicable

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Program Overview

Brooksville Academy is sixty bed program, for ages thirteen to eighteen-year-old males located in Brooksville County, Florida. The program is operated by Youth Opportunity Investments, LLC., through a contract with the Department. The contract was transferred to the current provider September 1, 2018. The program provides the following service: therapeutic services to address behavioral issues, mental health overlay services, and substance abuse overlay services. In addition, the program fosters each youth by providing Trauma Focused-Cognitive Behavioral Therapy, Seven Challenges, Skillstreaming the Adolescent, Young Men's Work, Teen Relationships, Forward Thinking, and Impact of Crime. Additional treatment services provided includes groups, individual therapy, and family therapy. Program administration is comprised of a facility administrator, assistant facility administrator, program director, business manager, administrative assistant, clinical director, health services administrator, and education coordinator. Case management services are provided by a director of case management and three case managers. Mental health staff at the program includes a clinical director, contracted psychiatrist, licensed therapists, four master's-level therapists, recreational therapist, contracted behavioral analyst, and transition services manager. Medical services are offered from 6:30 a.m. to 6:30 p.m. and are provided by a health services administrator, contracted designated health authority, and a registered nurse. Educational services are provided by Hernando County School System. The layout of the program includes: three independent buildings which include two open dormitories in each building, one administrative building which houses the kitchen, dining room, health clinical, and administrative offices, one maintenance building off limits to youth, and one education building. The program has twenty-nine operating security cameras providing coverage. At the time of the annual compliance review, the program had twelve vacant positions; ten youth care workers, one shift supervisor, and one licensed therapist.

Strengths and Innovative Approaches

- The program has community meetings and a student advisory board for youth to provide feedback and input regarding the program. The program utilizes a “Gotcha” reward system for positive youth recognition. Gotcha’s are a positive reward given to the youth by staff when the youth are caught doing the right thing or going above and beyond to assist staff. The gotcha’s are placed in a bucket and are pulled bi-weekly. The Gotcha winners if able to pass risk assessment will be taken off grounds for an activity such as bowling or a movie including dinner at a place of their liking.

- TLC Recognition (Teamwork, Leadership, Culture) can be awarded to staff by any supervisory employee of the provider or a stakeholder for demonstrating “Investing in Excellence” through teamwork, leadership or positive culture. When staff are caught doing the right thing, they receive a chip which they turn into the human resources manager to place their name in the monthly drawing. At the end of the month eight names are selected and are able to choose from several prizes such as provider clothing, a fifty dollar gift card, or four hours of approved paid leave.

Standard 1: Management Accountability

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

The program has a policy and procedures regarding initial background screening. Twenty-five staff were hired after the provider start date of September 1, 2018, requiring a clearance from the Department's Background Screening Unit (BSU) prior to hiring. Nine staff were hired prior to the clearance from the BSU. Eight of the nine staff background screenings cleared prior to completion of their pre-service training or any contact with the youth. One staff background screening was completed fifty-seven days after the staff hire date. Twenty-three staff had a local criminal history check completed prior to employment. One staff had the local criminal history check completed during the annual compliance review and one staff was missing a local criminal history check in their personnel record. There was documentation all staff passed a pre-employment assessment tool and a Central Communications Center (CCC) check prior to employment. All program staff were added to the Clearinghouse employment roster by the conclusion of the annual compliance review. The Annual Affidavit of Compliance with Level 2 Screening was completed for the program and the local school system providing education, both on January 10, 2019.

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

The program has a policy and procedures for completing five-year re-screenings. Due to the provider taking over the contract September 1, 2018, no staff were eligible for the five-year rescreening.

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

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

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

The program has a policy and procedures regarding the provision of an abuse free environment. The policy states all youth have unimpeded access to the Florida Abuse Hotline or the Central Communications Center (CCC) to self-report alleged abuse. When a youth requests to make a call, the supervisor is notified, takes the youth to a phone, and dials the number for the youth. If the call is accepted, the supervisor will obtain the case number and operator name. Seven personnel records were reviewed. Each record had a signed employee handbook receipt. The handbook includes the Code of Conduct for the program and provider. The Florida Abuse Hotline and CCC numbers are posted throughout the program. Since the provider took over the program on September 1, 2018, there was one staff reported to the CCC for improper conduct concerning a youth. The allegation was not validated. Seven youth were interviewed and all reported feeling safe at the program, staff are respectful, and they have never been stopped from calling the Florida Abuse Hotline. Four youth stated they have never heard staff use curse words when speaking to youth; two youth stated occasionally, and one stated once. Seven staff were surveyed and all were able to explain the process when a youth wants to call the Florida Abuse Hotline. All seven staff stated they had never observed a coworker tell a youth they could not call the Florida Abuse Hotline. Six staff stated they have never observed staff using profanity when speaking to youth.

1.04 Management Response to Allegations (Critical)	Satisfactory Compliance

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

The program has a policy and procedures regarding the provision of an abuse free environment. The program had one instance of alleged improper conduct reported to the Central Communications Center (CCC) since taking the contract over on September 1, 2018. The allegation was unsubstantiated, and the staff received refresher training in Protective Action Response (PAR). There were no incidents found to not have been reported.

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

The program has a policy and procedures regarding incident reporting and the Central Communications Center (CCC). The program has had fourteen incidents reported to the CCC since the contract start date of September 1, 2018. Five incidents were reviewed and all were reported to the CCC within two hours of the incident or the program becoming aware of the incident. All incidents were documented in the master log book. During the annual compliance review there was no evidence of incidents not being reported to the CCC. An interview with the facility administrator indicates all incidents reported to the CCC are discussed during the daily management team meeting.

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

The program has a policy and procedures regarding Protective Action Response (PAR). The program has had six PARs within the last six months. Five PAR reports were reviewed. All were completed by the end of the staff member's workday. All reports included the statements of all staff involved, a review by a PAR certified instructor/supervisory staff, and a post-PAR interview conducted within thirty minutes after the incident. Two of the reports had a PAR Medical Review conducted based on the post-PAR interview. Both youth were seen on-site by program medical staff. All reports had a review of the PAR incident by the facility administrator within seventy-two hours of the incident. A summary of PAR incidents is submitted to the Department monthly. The program has a PAR plan approved by the Department on January 11, 2019. An interview with the facility administrator indicated PAR reports are reviewed at the daily management team meeting to ensure all procedures were followed and to track trends identified. The program's PAR rate during the annual compliance review period was 0.45 which is below the statewide residential PAR rate of 1.51.

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

The program has a policy and procedures regarding pre-service training and certification. Seven staff training records were reviewed for pre-service training. All seven records indicated staff have been certified within sixty-days, exceeding the requirement of 180 days. All seven staff had completed cardiopulmonary resuscitation (CPR), first aid (FA), automated external defibrillator (AED), protective action response (PAR), ethics, suicide prevention, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA) training prior to any contact with youth. All seven records had the training documented in the Department's Learning Management System (SkillPro). The program submitted a written pre-service training plan to the

Department's Office of Staff Development and Training on January 19, 2019 and signed by the Department on February 7, 2019.

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

The program has a policy and procedures for annual in-service training. Since the provider took over the contract September 1, 2018, no staff were eligible for in-service training. The program submitted a written in-service training plan to the Department's Office of Staff Development and Training on January 19, 2019 and signed by the Department on February 7, 2019. The program has an annual in-service calendar.

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

The program has a policy and procedures regarding a grievance process. Seven pre-service staff training records were reviewed. All seven records had documentation the staff received the required training on the program grievance process and procedures. The program's grievance process includes an informal phase known as "Request to Speak", a formal phase, and an appeal phase. The policy includes the timeframe and steps for each phase. Seven youth were interviewed and all seven were familiar with how to file a grievance. All youth confirmed forms are placed throughout the program and they can ask for assistance in completing a grievance form. Seven staff were interviewed. All seven staff were familiar with the process for youth completing a grievance form and placing the form in the grievance box for review. The form is then given to the appropriate staff to address with the youth. The facility administrator was interviewed regarding the grievance process and confirmed if the youth's concern cannot be resolved with staff, the youth can complete a grievance form. The grievance form is reviewed the next morning and provided to the supervisor or program director for review. If the issue is still not resolved, it is forwarded to the facility administrator. The program maintains copies of the grievances since assuming the contract, less than twelve months ago. Five grievances were reviewed. All five grievances were resolved according to the program's policy and procedure.

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 utilizes Trauma Focused-Cognitive Behavioral Therapy, Seven Challenges, and Impact of Crime as the delinquency interventions. There are seven staff trained to facilitate the interventions. All the therapists have a master's-level degree. The staff facilitating groups have between three and twenty-four years' experience. The education and work experience are considered by the director of programming when determining which staff provides delivery of delinquency intervention services. The program is required to provide services according to the contract. An interview with the facility administrator confirmed the staff member's education and work experience are considered when determining which staff will deliver life skills training or groups. The youth are matched to staff and intervention groups by the review of the commitment packet. The lead case manager and clinical director review the commitment packet and determines the needs as well as if the youth's issues are mental health related or substance abuse related. The therapist as well as case managers are assigned according to their proficiency in the youth's problem area. All the program's interventions are evidence-based according to the Department's Sourcebook of Delinquency Interventions. The program's activity schedule provides structured, planned programming or activities at least sixty percent of the youth's awake hours. A review of the sign-in sheets show the groups are being delivered as designed. All staff are facilitating the evidence-based interventions are trained in the service to be provided. Seven youth case management records were reviewed. There was documentation all seven youth are receiving a delinquency intervention which is evidence-based, a promising practice, or a practice with demonstrated effectiveness. The youth are also participating in the following interventions: Skillstreaming the Adolescent, Teen Relationships, and Young Men's Work.

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 utilizes Skillstreaming the Adolescent as their life skills intervention. The youth received life and social skills intervention specifically addresses communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking. The program provides life skills training by master's-level therapists. The program's policy and procedure were reviewed to determine how the services are provided. The activity schedule shows life skills training is being provided to the youth. A review of the attendance sheets confirms the youth are receiving life skills training as outlined. The staff providing the interventions have been trained to provide the service. Seven youth case management records were reviewed and all had documentation of attending life skills groups. Seven youth were interviewed. All youth were able to list the different groups they participate in and skills they have learned in group to include coping and anger management skills.

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 utilizes Impact of Crime (IOC) for their restorative justice service. The program's restorative justice activities are designed to assist youth to accept responsibility for harm they caused by their past criminal actions, teach youth about the impact of crime on victims and their families and their communities, expose youth to victims' perspectives through victim speakers, and provide opportunities for the youth to plan and participate in reparation activities. The program is conducting these activities with the youth. There are three staff members trained to provide the IOC curriculum. The program's activity schedule provides four days for service delivery. An IOC group was observed during the annual compliance review week along with documentation which indicates the service is being provided as designed. Seven youth case management records were reviewed. Three youth had documentation of attending IOC groups; the other four youth did not have enough time left in the program to complete the group as designed. Seven youth were interviewed. All seven youth were able to list the different groups they participate in and skills they have learned in group. An interview with the facility administrator confirmed the program has weekly IOC groups where youth are taught the definition and application of restorative justice. In addition, all youth will participate in a community service project prior to the youth's release. While in the program, youth are able to participate in daily community service activities such as cleaning up the campus and having youth serve in the kitchen.

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

The program provides Young Men's Work as their gender-specific programming. This program addresses the needs of the targeted gender group. The service is designed for male youth who meet the common characteristics of the primary population. The program's activity schedule shows Young Men's Work is provided on Thursday's for both the mental health overlay service and the substance abuse overlay service youth. The program utilizes the Young Men's Work facilitator's guide as the manual. An interview with the facility administrator confirmed the gender-specific programming being provided at the program.

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 Department's Juvenile Justice Information System (JJIS). Upon recommendation from appropriate staff, JJIS alerts are downgraded or discontinued.*	

The program has a policy and procedures for internal alerts and for the Department's Juvenile Justice Information System (JJIS) alerts. Alerts are entered and removed by case managers, medical staff, or clinical staff. A review of the program's internal alert list and the JJIS alerts found the alerts were consistent, with no exceptions. An interview with the facility administrator confirmed the program's policy and procedures for entering and removing alerts. Seven staff were interviewed and all were able to describe several ways alerts are shared with staff including shift meetings, staff notification, and alert boards. Staff stated notifications are made through a variety of methods including shift meetings, alert board in supervisor's office, and a folder for each dorm which is updated as changes occur.

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 separates the youth record into three individual records. There is one record for case management, one for healthcare, and one for mental health and substance abuse services. Seven youth records were reviewed. Each of the three records included an individual case management record, an individual healthcare record and a mental health record. Each record was marked as "confidential". Each individual case management record has the required file tab to include the youth's name, Department identification number, date of birth, county of residence, and committing offense. Each individual case management record contained the sections to include legal information, demographic information, correspondence, treatment team activities, and miscellaneous. Each of the three individual records are labeled confidential and secured in a locked filing cabinet or locked room. Each filing cabinet is clearly labeled as "confidential".

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

The program has a policy and procedures to promote constructive input by youth. Seven youth were interviewed and all confirmed youth were aware of the process in place to provide input regarding the program. The youth can complete a "Request to Speak" form, attend community meetings, and speak to the student council representative for the youth advisory board. An

interview with the facility administrator confirmed the formal process to solicit youth input. The student council notebook was reviewed and had documentation of participants and minutes of meetings. The community meeting notebook was reviewed with documentation of participants to include the program administration and notes regarding discussion topics.

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

The program has a policy and procedures regarding the advisory board. The program has an established advisory board which includes representatives from law enforcement, judiciary staff, business community, school district, and faith community. The program director has recruited a children's advocacy group as representative of the victim services community and has recruited a parent/guardian of a previous youth involved in the juvenile justice system. Documentation indicated the advisory board met for the past two quarters. An interview with the facility administrator confirmed the advisory board is meeting quarterly and they continue to recruit additional community members.

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

The program has a policy and procedure regarding program planning. The program utilizes monthly youth and staff surveys as well as family surveys. The program has a staff moral committee to address staff turnover. The program has adjusted the staff schedule to lessen staff holdovers. The program also provides meals to staff during the day shift. Seven staff were interviewed, and all stated the program has monthly staff meetings as well as daily shift meetings. The interviewed staff stated the meetings were helpful, informative, and discussed relevant program related issues. Five staff stated they are briefed on program information to include compliance reports, youth surveys, and parent/guardian surveys. Three staff stated communication amongst the staff at the program is very good and four staff stated it is good.

1.19 Staff Performance	Satisfactory Compliance
The program ensures a system for evaluating staff, at least annually, based on established performance standards.	

The program has a policy and procedures for evaluating staff performance. Staff have a ninety-day probationary evaluation. Seven staff personnel records were reviewed. Each staff record had a ninety-day evaluation completed. The program staff are too new for annual evaluations. Annual evaluations will be conducted on date of hire anniversary dates according to the program policy. Seven staff were interviewed. Three staff stated there are yearly evaluations, three stated there are ninety-day reviews, and one stated they had not yet received an evaluation since being hired in October 2018. An interview with the facility administrator confirmed annual performance evaluations will be conducted on the staff's anniversary date of hire.

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.	

Seven youth case management records were reviewed. Six records had documentation of phone calls to parent(s)/guardian(s) on the youth's day of admission. One record had an updated notification regarding a phone call to the parent/guardian. Six of the seven records had documentation of a letter sent to the parent/guardian within forty-eight hours of admission; one letter was late. Although there was additional written correspondence to the parent approximately two weeks after the youth's admission, the notification letter was five weeks late. Six of the seven records had documentation of a letter sent to the committing court and juvenile probation officer within five working days; one letter was late. The notification letter was late by one month.

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.	

Seven youth case management records were reviewed. All seven records had documentation each youth was provided orientation on the day of admission. The orientation included services available, daily schedule, expectations and responsibilities of youth, written behavioral management system, access to medical and mental health services, anticipated length of stay, community access, grievance procedures, emergency procedures, physical design of the facility, and assignment to a living unit. An admission was not observed during the annual compliance review week. Seven youth were interviewed. All youth stated they had orientation within twenty-four hours of arriving at the program. All youth confirmed orientation included program rules and review of the daily schedule.

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

Three applicable youth case management records were reviewed for written consent of youth eighteen years and older. All three records contained documentation, signed by the youth, giving the program permission to speak with the youth's parent/guardian after the youth turned eighteen years of age.

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.*	

Seven youth case management records were reviewed for the classification process. All seven records reviewed had timely classifications for the youth which identified areas required and placed youth appropriately. Initial classification factors included physical characteristics, age, maturity level, any special needs, history of violence, gang affiliation, criminal behavior, and sexual aggression or vulnerability to victimization. There was documentation in all seven records indicating alerts in the Department's Juvenile Justice Information System (JJIS) are reviewed for any issues affecting classification. Documentation confirmed reassessments are completed when warranted for an increase in youth privileges, participation in work projects, and participation in off-campus activities. An interview with the facility administrator confirmed the practice and procedures used by the program for classifying youth.

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.	

Three applicable youth case management records were reviewed for gang notification to law enforcement. All three records had documentation law enforcement for the youth's home county and program location were notified of documented or suspected gang members. All three youth records had documentation the youth were appropriately identified on the program's internal alert system. All three had documentation the youth's juvenile probation officer and education staff were notified.

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.	

Three applicable youth case management records were reviewed for gang prevention and intervention. All three youth had documentation of participation in gang prevention and intervention strategies. Each individual performance plan had specific interventions which included groups, essays, and abstinence from gang related behavior. The program utilizes Impact of Crime curriculum for gang intervention strategies. During the annual compliance review, three instances of gang related drawings were noted; none of which were part of a permanent structure. Two were on erasable surfaces and one was on notebook paper; all three were removed immediately when identified.

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.	

Seven youth case management records were reviewed for the initial Residential Positive Achievement Change Tool (R-PACT) and reassessments. All seven records had documentation the initial R-PACTs were completed within thirty days of admission and maintained in the Department's Juvenile Justice Information System (JJIS). Six youth records had documentation of the R-PACT reassessment being completed within ninety-days of the initial R-PACT. One R-PACT reassessment was nineteen days late. There was documentation of the R-PACT reassessment maintained in each youth record.

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

Seven youth case management records were reviewed for the Youth Needs Assessment Summary (YNAS). All seven records contained the YNAS completed within thirty days of admission. Each YNAS was documented in the Department's Juvenile Justice Information System (JJIS).

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

Seven youth case management records were reviewed. All seven individualized performance plans (IPPs) were developed within thirty days of the youth's admission. All seven IPPs were developed after the initial assessment. All seven records had documentation the treatment team was present during the development of the IPP to include the treatment leader, youth, administrative representative, living unit representative, treatment staff, and educational staff. All seven IPPs had signatures of the youth and all parties who have significant responsibility in goal completion. All seven records contained documentation the IPPs were mailed to the

parent/guardian for signature. The IPPs contained goals developed from the top three criminogenic needs youth had on the Residential Positive Achievement Change Tool (R-PACT). The IPPs contained transition objectives, academic plans, and treatment plans. The IPPs included youth and staff responsibilities. Specific objectives were noted for youth and staff, all of which had target dates. Five of seven of the IPPs were mailed out timely to the parent/guardian, committing judge, and juvenile probation officer. One was mailed out thirty days after the IPP was developed. Seven youth were interviewed and all were able to explain the treatment process to include treatment team meetings and current goals. All seven youth stated they received a copy of their performance plan.

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

Seven youth case management records were reviewed for performance plan revisions. All records had documentation of performance plan revisions to reflect progress in completion of objectives and goals or reassessment of risk factors. Goals were closed when completed and new goals were added when new domains identified new criminogenic needs.

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.*	

Seven youth case management records were reviewed. Ninety-day performance plan summaries were completed for all seven records reviewed. Six of the seven summaries were completed every ninety calendar days. One summary was seven days late. Each performance summary includes the youth's status on the goals, overall progress in treatment, academic status, behavior, level of motivation to change, interaction with peers and staff, overall behavior and any significant positive or negative events. The youth were given the opportunity to read and add comments prior to signing. All seven youth were provided a copy of the summary. The original summary was filed in the youth case management record. Each summary was signed by the treatment team leader, staff member preparing the summary, administration, and youth. The records showed copies of the summary were sent to the committing court, juvenile probation officer (JPO), and parent/guardian within ten days. Three closed records were reviewed for release summaries. All three records showed a summary with justification for release sent with a Pre-Release Notification to the supervising JPO. No records contained an objection by the court. The program provided letters to all three parents/guardians of the anticipated release dates. Seven youth were interviewed and all stated they received a copy of the performance summary sent to the court.

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.	

Seven youth case management records were reviewed for parent/guardian involvement in case management services. The program encourages and facilitates involvement of the youth's parent/guardian in the case management process including the assessment process, development of the youth's performance plan, progress reviews, formal treatment team, and transition planning. Treatment team was not available to be observed during the annual compliance review. An interview with the facility administrator confirmed the program encourages parental involvement in the case management process. Seven youth were interviewed and all stated their parent/guardian is involved in the case management process.

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's treatment team members included the treatment team leader, youth, administrative representative, living unit representative, treatment staff, educational staff, juvenile probation officer, and parent/guardian. The program's gang prevention specialist, the director of case management, is also included, when applicable. Seven youth case management records were reviewed. All seven records contained documentation reflecting all required parties were identified and in regular attendance at treatment team reviews.

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.	

Seven youth case management records were reviewed for incorporation of other plans into the performance plan. All seven records contained clear reference to other applicable plans for treatment and academics.

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.*	

Seven youth case management records were reviewed. Each record contained documentation formal treatment teams were held every thirty days. The youth's juvenile probation officer (JPO), parent/guardian, and other parties needed were invited to participate by letter or e-mail. Each

record had documentation for the formal performance reviews to include the youth's name, date of review, a list of all meeting attendees, comments from all members, an overview of youth's progress, any revisions to the performance plan and goals progress, positive and/or negative behaviors, any behavior which resulted in a physical intervention by staff, treatment progress, and if the youth was given a new Residential Positive Achievement Change Tool (R-PACT). Each youth is provided an opportunity to demonstrate skills acquired in the program. Bi-weekly informal reviews are also held, including all the information presented at the formal review. Treatment team was not available to be observed during the annual compliance review. Seven youth were interviewed. All seven youth stated they are given an opportunity during treatment team meetings to demonstrate skills they have learned in the program.

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

Three closed youth case management records were reviewed. All three records included a completed employment application, a résumé, an appointment with Career Source Center, appropriate documents essential to obtaining employment and documentation the youth's parents/guardians and the juvenile probation officer (JPO) are aware of the vocational plan for the youth. The vocational program and career education is appropriate for the age and abilities for the youth in the program. The career education programming offered at the program is Type 2 which educates the youth on communication, interpersonal, and decision-making skills. The career education program is appropriate for the length of stay and custody characteristics of the youth in the program. Interviews with the facility administrator and lead teacher confirmed vocational programming is offered through a variety of curriculum.

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

Hernando County Public Schools provide the educational instruction on a 250-day calendar, classes are scheduled in six fifty-minute blocks to include 300 minutes of daily instruction time. The youth receive credits for the education and training received while at the program. The activity schedule and logbook document minimal interference of education instruction. Seven youth were interviewed. Five youth stated there are not a lot of interruptions during educational instruction. One youth stated the interruptions are inconsistent, but most days are good. One youth stated the when interruptions do occur, direct care staff address it in order to allow education to continue. An interview with the lead teacher confirmed education instruction is conducted as scheduled at the program.

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

Three closed youth case management records were reviewed for employability as a transition goal and included provisions for continuation of education and/or employment, a sample completed application, a résumé, and documentation the youth's case manager and parent/guardian are aware of the plan. Three closed records were reviewed for educational

transition plan. Each record had an individual education transition plan developed based on youth's post release goals, beginning at admission, to include all key personnel related to transition activities, and included responsibility requirements, and post-release needs.

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.*	

Four open and three closed youth case management records were reviewed for transition planning. All seven transition conferences were held at least sixty days prior to the targeted release date. Transition conferences were attended by the youth, treatment team leader, administration, and other team members in all seven records. For six of the records, there was documentation the youth's juvenile probation officer (JPO) and parent/guardian were invited and encouraged to attend. One youth record did not include documentation the parent/guardian and JPO were invited. All seven records had documentation the education staff were invited. The transition conference included a review of transition activities on the youth's performance plan, identified additional transition activities, and identified persons responsible for completion in all seven records. Six records had documentation of identified target completion dates; one record did not include those dates. The transition conference was signed and dated by all participants. Four of the seven youth records were applicable for a Community Re-entry Team (CRT) meeting. Three youth are still in the program and pending a CRT meeting. In four of the applicable CRT meetings, the youth and case manager participated.

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.	

Three closed youth case management records were reviewed for the exit portfolio. All three records contained state-issued identification cards, copy of the youth's transition plan, appointment calendars, résumés, appointment calendars, birth certificates, employment applications, education records, and documentation the youth received the portfolio. None of the closed records contained the social security card, but all of them had documented efforts to obtain it.

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

Three closed youth case management records were reviewed for the exit conference. All three records had documentation of exit staffings completed at least fourteen days prior to the youth's release. All records had documentation the required items in the exit portfolio and transition activities were discussed. All three exit staffings were separate meetings from the Community Re-entry Team meetings. All release dates were correctly reflected in the Department's Juvenile Justice Information System (JJIS). Two of the exit plans did not include the signatures of the juvenile probation officer, parent/guardian, and educational staff; their participation is not clearly reflected on the plan. Chronological note entries reflected all involved parties participated in the exit conference.

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 designated mental health clinician authority (DMHCA) is the program's full time clinical director, who is also a licensed mental health counselor (LMHC). The DMHCA has a clear and active license in the State of Florida, which expires March 31, 2021, and is also a qualified mental health counselor supervisor. The DMHCA is on-site forty hours a week to ensure appropriate coordination and implementation of mental health and substance abuse services are taking place. The DMHCA is responsible for coordinating and verifying implementation of necessary and appropriate mental health and substance abuse services in the facility. A copy of the license and position description were reviewed. An interview with the DMHCA indicated she oversees the delivery of clinical services consisting of individual, family, and group therapy sessions. The DMHCA is responsible for assisting and supervising case management and clinical staff. The DMHCA also monitors all service provisions through a review of all clinical documentation related to mental health and substance abuse treatment in the form of progress notes, treatment plans and reviews, and comprehensive assessments to ensure each youth receives daily 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 a licensed mental health professional who is a licensed mental health counselor (LMHC) in the position of designated mental health clinician authority (DMHCA). The LMHC has a clear and active license in the State of Florida. The DMHCA is also a qualified mental health counselor supervisor. The DMHCA is a full-time employee and available for contact twenty-four hours a day, seven days a week. The program has a contract with a psychiatrist who is on-site biweekly. The psychiatrist has a clear and active license in the State of Florida, which expires January 31, 2021 with a specialty in adult psychiatry. There were no records of adverse emergency actions, discipline or complaints attached to the psychiatrist's license. A review of documentation from the past six months confirmed the psychiatrist was on-site biweekly with no exceptions. Each youth admitted into the program receives an initial psychiatric evaluation within fourteen days of admission. The program is licensed in accordance with Chapter 397, Florida Statutes, to provide substance abuse services. This license was certified by the Department of Children and Families and expires in August of 2019.

3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff	Limited 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 four non-licensed mental health clinical staff providing mental health and substance abuse services. All four non-licensed staff hold master's-level degrees from an accredited educational institution. One staff's area of study is in Divinity and the program was unable to provide transcripts to confirm if courses included counseling, therapy skills, treatment model and program philosophy, therapeutic milieu, behavior management, client rights, crisis intervention, early intervention and de-escalation, documentation requirements, normal and abnormal adolescent development, and typical behavior problems. The Department's Office of Health Services and Office of Residential Services is working with the provider to address concerns regarding this non-licensed clinical staff. Two non-licensed staff completed two of seven Assessments of Suicide Risk (ASR). One non-licensed staff is no longer employed, and the required training to conduct ASRs for the other non-licensed staff who remains employed, was not provided. While the program was unable to provide documentation that either of the staff had received twenty hours of training in ASRs, a review of the qualification and training for the same two non-licensed staff who conducted ASRs was completed during the last annual compliance review on April 3, 2018 under the previous provider and found to be adequate. All four of the non-licensed clinical staff work forty hours a week and coverage is divided to ensure a clinical staff is on-site seven days a week. The designated mental health clinician authority (DMHCA), who is a licensed mental health counselor (LMHC), provides weekly of on-site face-to-face supervision with the four non-licensed mental health clinical staff. A review of documentation from the past six months indicated supervision had been conducted each week with no exceptions. The weekly supervision was documented on a form similar to the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log (MHSA 019) form and includes all the required information. Seven youth mental health records were reviewed, and each mental health substance abuse evaluation, initial treatment plan, and individual treatment plan completed by a non-licensed clinical staff was reviewed and signed by the DMHCA within ten calendar days as required.

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 mental health and substance abuse admission screening. Seven youth mental health records were reviewed. All seven records had documentation reflecting existing mental health and substance abuse information was reviewed from each youth's commitment packet. All seven youth had a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) administered on the day of admission completed by trained staff and were entered in the Department's Juvenile Justice Information System (JJIS) on the same day. One of seven MAYSI-2 assessments indicated a further assessment was required. All newly admitted youth are referred for a Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation, which is part of the program's practice. All

newly admitted youth are administered an Assessment of Suicide Risk (ASR) as part of the intake process as well. Documentation confirmed each youth had an ASR completed during intake. The facility administrator (FA) and clinical director were both notified before each youth was placed on standard supervision as a result of the ASR. Additional screenings completed by the program at intake include the Substance Abuse Subtle Screening Inventory (SASSI) and Beck's Depression Inventory (BDI). An interview with the FA confirmed the intake process is a collaboration with case management and mental health. The intake process includes a review of the MAYSI-2 and other mental health and substance abuse information.

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 related to mental health and substance abuse assessments and evaluations. Seven youth mental health records were reviewed, and each youth was referred for a new mental health evaluation on the day of admission. Six of seven youth had a mental health evaluation completed within thirty calendar days of admission. The remaining youth's evaluation was completed forty-eight days after admission. Five of seven evaluations were completed by a non-licensed mental health clinical staff member and were signed by a licensed mental health professional within ten calendar days after the evaluation was completed. The new evaluation included the following: demographic information, reason for evaluation, relevant background information, behavioral observations, mental status examinations, interview or procedures administered, discussion of findings, diagnostic impression, and recommendations. Each evaluation also included a substance abuse assessment which included the following: patterns of alcohol and other drug abuse, impact of alcohol and other drug abuse on major life areas, and risk factors of continued alcohol and other drug abuse. All seven youth had a signed consent for substance abuse services.

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 regarding mental health and substance abuse treatment. Seven youth mental health records were reviewed. All seven youth are assigned to a treatment team upon their arrival to the program. The multidisciplinary team is comprised of the following: youth, program administration, direct care staff, education, medical staff, and mental health staff. The same members are documented on the treatment team forms with the exception of administration. Treatment team was not available to be observed during the annual compliance review. Reviewed documentation reflected each youth received individual, group, and family counseling as prescribed by their treatment plan without exception. Five of seven youth receiving mental health treatment had an Authority for Treatment and Evaluation (AET). One youth was eighteen and one youth was in the custody of the Department of Children and Families and had the required court order. All seven youth had a signed Youth Consent for

Substance Abuse Treatment Form and a Youth Consent for Release of Substance Abuse Treatment Records forms (MHSA012 and MHSA013), even if they were not receiving substance abuse treatment. Treatment progress notes are documented on a form containing all the required information similar to Department's Counseling/Therapy Progress Note form (MHSA018). Group therapy is limited to ten or fewer youth for mental health groups and fifteen or fewer youth for substance abuse groups as documented on the group sign-in sheets. All staff providing group are qualified to provide services. Seven staff were interviewed, and all confirmed direct care staff do not conduct mental health or substance abuse groups. An interview with the DMHCA indicated she oversees the delivery of clinical services consisting of individual, family, and group therapy sessions

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 regarding mental health and substance abuse treatment and discharge planning. Seven youth mental health records were reviewed and all had an initial treatment plan provided on the date of admission. The initial mental health and substance abuse plan is documented on the Department's Initial Mental Health/Substance Abuse Treatment Plan (MHSA 015) form. The initial treatment plan is signed by the non-licensed clinical staff completing the form and signed by the licensed mental health professional. The initial treatment plan is signed by other members of the treatment team. Each initial treatment plan had documentation indicating it was mailed to the parent/guardian. One of the seven was signed by the parent/guardian. All seven individualized treatment plans were developed for each youth within thirty days of admission. The individualized treatment plan is developed on the Department's Individualized Mental Health/Substance Abuse Treatment Plan (MHSA 016) form. The individualized treatment plan is signed by the non-licensed clinical staff completing the plan and signed by the licensed mental health professional within ten days of completion. The plan is signed by all treatment team members, including the psychiatrist for youth requiring psychiatric services. Each youth had treatment plan reviews every thirty days following the development of the individualized treatment plan. The treatment plan review is documented on the Department's Individualized Mental Health Treatment Plan Review (MHSA 017) form. Each plan prescribed services for individual, group, and family counseling. Three closed youth mental health records were reviewed for discharge plans. All three had a discharge plan documented on the Department's Mental Health/Substance Abuse Treatment Discharge Plan (MHSA 011) form. None of the youth were at suicide risk upon release. Each discharge plan included a recommendation of follow-up services for daily maintenance. Each discharge plan had documentation the plan was discussed with the youth, parent/guardian, and juvenile probation officer (JPO) at the transition and exit conferences. There was documentation validating a copy of the discharge plan was provided to the youth and parent/guardian in all three records, and the JPO in two of 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 is contracted to provide both mental health overlay services (MHOS) and substance abuse overlay services (SAOS), as required by the contract. Each youth, at a minimum, receives mental health services which includes individual, group, and/or family counseling five days a week. Additionally, substance abuse and clinical activities inclusive of psychosocial skills training and supportive counseling are provided, at a minimum, five days a week. Mental health groups provided do not exceed ten youth for each group and substance abuse treatment is limited to fifteen youth for each group. The designated mental health clinician authority (DMHCA) is a licensed mental health counselor (LMHC) who is on-site forty hours each week. Each of the four non-licensed clinical staff are on-site forty hours each week, including weekends, to ensure a clinical staff is on-site seven days a week. A review of seven youth mental health records confirmed mental health services are being provided seven days a week. An interview with the DMHCA indicated additional interventions provided include Seven Challenges, Impact of Crime, Cognitive Behavioral Therapy, Skillstreaming the Adolescent, and Life Skills Training. The non-licensed mental health clinical staff carry caseloads of fifteen youth each. An interview with the program director confirmed group mental health services are held daily.

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 contract with a psychiatrist who is on-site bi-weekly. The psychiatrist has a clear and active license in the State of Florida with a specialty in adult psychiatry. Each youth admitted into the program receives an initial psychiatric evaluation within fourteen days of admission. Seven youth mental health records were reviewed for psychiatric services. All youth received an initial psychiatric evaluation within fourteen days of admission, regardless of their medication status. One youth arrived at the program on psychotropic medication. Upon his initial psychiatric evaluation, the psychotropic medication was discontinued and the parent/guardian was informed of the medication discontinuation. Three additional youth were prescribed psychotropic medication subsequent to their admission. The initial diagnostic psychiatric interview included the following: history of medical, mental health, and substance abuse, mental status examination, Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV), treatment recommendations, prescribed medications, explanation of the need for psychotropic medication, and frequency of medication monitoring. The evaluation was clearly identified as an "initial diagnostic psychiatric interview" in three of seven cases. Page three of the Clinical Psychotropic Progress Note (CPPN) was also completed for each youth. There was documentation reflecting the three youth on psychotropic medication have been seen for a medication review by the psychiatrist at a minimum of every thirty days. A review of documentation for the past six months confirmed the psychiatrist is on-site bi-weekly, with no exceptions, as required by the contract. The psychiatrist is available for emergency consultation twenty-four hours a day, seven days a week. An interview with the psychiatrist confirmed his

role in the coordination and implementation of psychiatric services in the program is to evaluate and manage medication. An interview with the designated mental health clinician authority (DMHCA) confirmed ongoing consultation with the psychiatrist bi-weekly to review each youth's behavior and any concerns. A review of mental health records indicated the psychiatrist signs all individual treatment plans and treatment team reviews for youth who are prescribed psychotropic medication. The facility operating procedures related to psychiatric services and psychotropic medication are reviewed annually, with the latest review occurring on September 1, 2018. There are no standing orders for psychotropic medications or 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 written plan detailing suicide prevention procedures. The program's suicide prevention plan includes identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and a review process. The program's suicide prevention plan is reviewed annually. The plan was reviewed and signed by the facility administrator and corporate representative on September 1, 2018.

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

The program had two youth placed on suicide precautions during the annual compliance review period. Due to admission screenings and staff observations, the youth were determined to be at risk. In both cases, the youth had a completed Department Assessment of Suicide Risk (ASR) (MHSA 004). As a result of the ASR, the youth were placed on constant supervision. The suicide precaution observation (PO) logs were completed correctly to include documented "safe housing areas". Supervision was documented on the PO logs and the precautionary observation was authorized. A follow-up ASR was completed prior to the removal of the youth from precautionary observation. The follow-up ASR included all the required elements. A conference was held between the program director and licensed mental health professional to reduce the level of supervision. The parent/guardian was notified of the suicide precautions. The initial ASRs were completed by non-licensed staff and reviewed by a licensed mental health professional. One follow-up ASR was completed by a non-licensed clinical staff under the supervision of a licensed mental health professional. A Department Juvenile Justice Information System (JJIS) suicide alert was initiated and removed for both youth being placed on suicide

precautions. The ASR was completed immediately after concerns were observed then placed on suicide precautions.

Each of the ASRs were completed by a non-licensed staff and documentation of their training/qualification was not provided by the program. While the program was unable to provide documentation the mental health clinical staff had received twenty hours of training in Assessment of Suicide Risk (ASR), a review of the qualification and training for both non-licensed staff who conducted ASRs was completed during the last annual compliance review on April 3, 2018 under the previous provider and found to be adequate. There was documentation in the logbook for the beginning and end times of suicide precautions for one of two youth. There was no logbook entry for one youth's precautionary observation placement, instructions, or discontinuation. There was no documentation on the ASR of the parent/guardian and JPO notification for one youth's precautionary observation placement.

The program has a suicide response kit located on each dorm. Seven staff were interviewed, and all staff were able to describe what to do in the event a youth expresses suicidal thoughts. All seven staff were able to identify the suicide response kit is kept on each dorm.

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

The program had two youth who were placed on suicide precaution during the annual compliance review period. The precautionary observation (PO) logs were maintained for the duration the youth was on suicide precaution. The appropriate level of supervision and observations of the youth's behavior were documented in real time. The documented times did not exceed thirty-minute intervals. No warning signs were documented to have been observed. The PO logs were reviewed and signed by each shift supervisor as well as reviewed and signed by the licensed mental health professional. The PO logs documented safe housing requirements. One youth placed on suicide precaution was interviewed and stated staff was always with him and he was never left alone for any period of time. The remaining youth had been released from the program prior to the annual compliance review period.

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.	

Seven staff training records were reviewed for pre-service training. All staff had documentation of six hours of suicide prevention training. The past two completed quarters were reviewed for mock suicide drills. A drill was conducted during the past two quarters on each shift. All six drills included the mock use of the suicide response kits, use of 9-1-1, cardiopulmonary resuscitation (CPR), and the automated external defibrillator (AED). The program still has six weeks remaining to ensure all staff with direct youth contact participates in a suicide drill.

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

The program has a written mental health crisis intervention services plan. The written mental health crisis intervention services plan includes, at a minimum, the following: notification and alert system, means of referral (including youth self-referral), communication, supervision (one-to-one, constant, and standard supervision), documentation, and review process. The written mental health crisis intervention services plan was reviewed and signed by the facility administrator and a corporate representative on September 1, 2018.

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

The program has a written mental health crisis intervention services plan, which was reviewed and signed by the designated mental health clinician authority (DMHCA) and facility administrator on September 1, 2018 and will utilize an internal form as its crisis assessment tool, which is comparable with the Department's Crisis Assessment form (MHSA 023). The program has not completed any crisis assessments during the annual compliance review period.

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

The program has a written emergency mental health and substance abuse services plan. The written emergency mental health and substance abuse services plan includes, at a minimum, the following: immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health services or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394 FS (Baker Act), transport for emergency substance abuse assessment and treatment under Chapter 397 FS (Marchman Act), documentation, training, and review process. The written emergency mental health and

substance abuse services plan was last reviewed and signed by the designated mental health clinician authority (DMHCA) and facility administrator on September 20, 2018.

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

The program has not had any Baker Acts or Marchman Acts during the annual review period; therefore, this indicator rates as non-applicable.

Standard 4: Health Services

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

The designated health authority (DHA) is a licensed osteopathic physician who holds an unrestricted license and meets all requirements for independent and unsupervised practice in the State of Florida. The DHA is board certified in family practice. The DHA has a contract with the program to provide medical services to the youth in the program. The DHA is on-site weekly and is on call twenty-four hours a day, seven days a week. A review of the sign-in logs found the DHA was on-site each week for the past six months. There was documentation the DHA reviewed the medical documentation for all youth. In the event a youth needs to be seen prior to the DHA's regular scheduled time at the program, the youth can be transported to the DHA's office or seen at a local clinic. The DHA signed and dated all medical policies and procedures. The licenses for both registered nurses (RNs) were current. In the event the DHA is on leave and a youth needs to be seen, the youth can be transported to the DHA's office to be seen by another physician in the practice.

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

There is documentation an annual review of all health-related facility operating procedures (FOP) is completed by both the facility administrator (FA), designated health authority (DHA), and nurses annually. The nursing staff reviewed, signed, and dated a cover letter which states they will follow treatment protocols. There are treatment protocols for non-healthcare staff for use when no nurse is available. There are no standing orders concerning psychotropic medications. The director of nursing provided an outline for training any newly hired nursing staff.

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.	

Seven youth individual healthcare records (IHCR) were reviewed for an Authority for Evaluation and Treatment (AET). A current AET was signed by a parent/guardian for five of the seven youth records. Each AET was a copy and clearly labeled with the word copy. One youth was eighteen years of age and did not require an AET. One youth was under the care of the Department of Children and Families and had a signed limited scope AET.

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.	

Seven youth individual healthcare records (IHCR) were reviewed. Six of the youth records required documentation for over-the-counter medications beyond those covered by the Authority

for Evaluation and Treatment (AET). For new medications, verbal attempts were documented in four of the six applicable IHCRs. In one youth's IHCR verbal consent was not witnessed and no attempt for verbal consent was obtained for antibiotic therapy. Written notifications were sent regardless of telephone notifications in six applicable record. One of the youth IHCRs required, and was sent, a notification be sent for emergency care.

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

Four youth individual healthcare records (IHCR) were applicable for notification regarding the Clinical Psychotropic Progress Note (CPPN). All reviewed youth IHCRs documented the CPPN was mailed for the initiation of psychotropic medication. One applicable record had documentation notification was sent for significant changes or discontinuation of psychotropic medication. All reviewed youth IHCRs had documentation of witnessed verbal consent being obtained for the CPPN. Written notification is sent to the parent/guardian on the Department's Acknowledgment of Receipt Form of CPPN.

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

Seven youth individual healthcare records (IHCRs) were reviewed and documentation in each IHCR consistently demonstrated verification of immunization within thirty days of admission. An interview with the nurse confirmed the program uses the Department's Immunization Tracking Record and Florida Shots to verify immunizations. No youth record had either documentation of a refusal for immunization or a declaration for religious exemption.

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.	

Seven youth individual healthcare records were reviewed and each of the youth had completed a Facility Entry Physical Health Screening (FEPHS) form completed upon admission. All youth FEPHS forms were completed by a registered nurse (RN).

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

Seven youth individual healthcare records (IHCR) were reviewed for medical alerts. There was documentation in each youth IHCR the medical alerts were confirmed by a registered nurse and entered into the Department's Juvenile Justice Information System (JJIS). Five of the youth had a medical grade of three to five. The youth on psychotropic medications were documented on the internal alert list and in JJIS. Three youth had other alerts not consistent with the internal alert list and JJIS. Those alerts were corrected when the nursing staff was notified of the

discrepancy. Three staff had their alerts verified by the nursing staff and updated on the internal alert list. One youth was not applicable. Dietary alerts are posted in the kitchen, beside the serving line, so staff can see the alerts when preparing the meals. Interviews with staff confirm they are notified of alert information during shift briefing, documentation in the applicable dorm logbook, and with the alert board in the supervisor's office.

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.	

Seven youth individual healthcare records were reviewed, and each contained documentation the youth received healthcare orientation within twenty-four hours of admission to the program. The healthcare orientation topics include how to access sick call, notify staff immediately when they are having medication side effects, the right to refuse care, what to do in case of sexual assault, and the non-disciplinary role of the health care providers, what constitutes an emergency, how medications are administered, notification to staff of any chest pain, extreme shortness of breath, or faintness while exercising, and situations in which health care must notify the direct care staff.

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.	

Seven youth individual healthcare records were reviewed, of which four were applicable for notification to the designated health authority (DHA) concerning a chronic condition. The DHA was notified by telephone in all applicable records. Each notification was documented in the youth's intake progress note. None of the youth were identified as in-need of an emergency response. The program's practice is to inform the DHA of each admission to the program without exception.

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.	

A review of seven youth individual healthcare records (IHCRs) found four were applicable for a healthcare admission rescreening. All IHCRs had a Facility Entry Physical Health Screening (FEPHS) form completed by a registered nurse (RN), upon the youth's return to the program.

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.	

Seven youth individual healthcare records (IHCRs) were reviewed, and each contained a new Health Related History (HRH), completed on the date of admission to the program. Each HRH was documented on the Department's Health Related History form by a licensed nurse and reviewed by the designated health authority (DHA) on their next site visit. All were completed before, or at the same time as, the Comprehensive Physical Assessment (CPA).

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

Seven youth individual healthcare records (IHCR) were reviewed, and each had a new Comprehensive Physical Assessment (CPA) which was completed using the Department's Individual Health Care Record Checklist and Internal Quality Control form. All seven youth records had a current CPA completed by the designated health authority (DHA) within seven days of admission. All sections of the CPA were addressed. Each youth had a medical grade documented. The Department's Problem List was updated as needed for all seven youth.

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 a 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.	

Seven youth individual healthcare records (IHCRs) were reviewed. All had documentation of a tuberculin skin test (TST) completed within the last year. In each IHCR, the tuberculosis (TB) screenings are documented on the Comprehensive Physical Assessment (CPA). Additionally, all youth had the screening documented on the Infectious and Communicable Diseases (ICD) forms. In each youth record, the Tier I TB screening is completed on the Facility Entry Physical Health Screening form.

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

Seven youth individual healthcare records (IHCRs) were reviewed. A Sexually Transmitted Infection (STI) Screening was completed by the registered nurse (RN) on the day of admission in each record reviewed. Each STI screening was reviewed by the designated health authority (DHA) within seven days of admission. Seven of the youth had testing ordered by the DHA and was completed on day of admission. Test results were noted on the Infectious and Communicable (ICD) form.

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.	

Seven youth individual healthcare records (IHCRs) were reviewed, and each had documentation the youth was offered a referral for human immunodeficiency virus (HIV) testing. Four of the youth consented for a HIV test. The pre- and post-test counseling are completed by the designated health authority. Documentation of the pre- and post-test counseling is

documented on the IHCR. The youth HIV results are marked confidential and sealed in a envelope. Seven youth were interviewed, and all reported they could request an HIV test.

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

Sick call is scheduled and conducted each day, by a registered nurse (RN). When a licensed nurse is not on-site, the supervisor checks the sick call box and notifies the RN as needed. Seven youth individual healthcare records (IHCRs) were reviewed, and no youth presented with a similar sick call complaint three or more times within a two-week period. One youth presented with a complaint of severe pain which staff were not familiar and the youth was transported to the emergency room. The completed Sick Call Request forms are filed with the progress notes in youth's IHCR. Seven youth were interviewed with six youth stating they could see a nurse within one day of the request. One youth stated he could see the nurse immediately.

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.	

Sick call is scheduled and conducted each day, by a registered nurse (RN). When a licensed nurse is not on-site, the supervisor checks the sick call box and notifies the RN as needed. No sick call was observed during the annual compliance review. Seven youth individual healthcare records (IHCRs) were reviewed and six youth records were applicable for sick call. Each of those encounters were documented on the sick call index and in the program's sick call referral log with no exceptions. Sick calls were documented the progress notes in each youth's IHCR. The Sick Call forms are filed in the youth's IHCR in reverse chronological order. All Sick Call forms included the youth's signature to indicate the youth had been seen. Seven youth were interviewed regarding how soon they could see an RN for a sick call request. Six indicated they could see an RN within one day and one youth stated immediately. Seven staff were interviewed, each of them reported the RN (two staff interviews also reported shift supervisor or staff) is the one who conducts sick call.

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

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

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

A review of seven youth individual healthcare records (IHCR) found three had documented first aid and episodic care. Each of the episodic care encounters were logged in the program's episodic care log. All episodic care encounters were conducted by a registered nurse (RN). The program's protocols were reviewed with emergency medical and dental care available twenty-

four hours a day. The location of the first aid kits, automated external defibrillator, wire cutters, and knife-for-life were observed. First aids kits were located in the kitchen, one in each dorm building, one in the Home Builder's Institute classroom, one by the pool, and one for each transport vehicle. An interview with the director of nursing indicated the first aid kits are checked monthly. Seven youth were interviewed. All seven stated they could see a dentist for tooth pain or a doctor if needed.

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

The program has a policy and procedures for emergency care. Emergency medical, dental, and emergency medical services (EMS) are available twenty-four hours a day. There is one automated external defibrillator (AED) located in administration. The AED is checked to verify the battery is working. An AED test was conducted and was observed to be in working order. The battery was changed in April 2016 and expires May 2020. The pads were changed in March 2018 and expire October 2020. Emergency medical drills were reviewed for the past six months. The drills were conducted at least quarterly, on each shift. The drills include cardiopulmonary resuscitation (CPR) and AED demonstrations. Emergency numbers for staff are posted in the dorm building offices, medical office, and the supervisor's office and inaccessible to the youth. Appropriate supervisory staff are trained in the administration of the EpiPen auto injector. Seven staff were interviewed and all stated they are personally allowed to call 9-1-1 if a youth has a medical emergency.

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

A review of seven youth individual healthcare records (IHCR) found four were applicable for off-site care. All records included documentation of parent/guardian notifications. The Summary of Off-Site Care form was utilized and filed in each of the youth's IHCR along with discharge documents. The designated health authority (DHA) signed or initialed all the Summary of Off-Site Care forms and supporting documents and all were filed in the youth's IHCR. All youth received follow-up testing, appointments required, referrals, and follow-up care within a timely manner.

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.	

A review of seven youth individual healthcare records (IHCR) found four were identified with chronic conditions. Three of the four youth are taking prescribed medication on an on-going basis. All four youth had an initial assessment for their condition and were seen every ninety days or is scheduled to be seen every ninety days. An interview with the designated health authority (DHA) and the nurse confirmed the program's practice. Each youth's chronic condition is placed on the alert log and chronic clinic list, which is updated by the director of nursing. An

interview with the facility administrator indicated he meets with the director of nursing weekly to review important medical issues pertaining to youth in the program.

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

Seven youth individual healthcare records (IHCR) were reviewed, of which three youth had documentation of entering the facility with their prescribed medication. Each youth was received from another Department of Juvenile Justice program. All three youth IHCR had documentation the medication was verified. Each of the IHCRs had a list of medications the youth was taking at the time of admission. Each IHCR had documentation the designated health authority and/or psychiatrist was contacted to continue the specified 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.	

A review of seven individual healthcare records (IHCRs) found five were applicable for medication management. Valid medication orders were in place for each prescription medication and over-the-counter (OTC) medication to be taken on a regular basis. Standing orders for OTC medications were also signed by the designated health authority (DHA). All five applicable records confirm all medications have a current, valid order and are given pursuant to a current prescription. For OTC medications administered which were not on the Authority for Evaluation and Treatment (AET) notifications were mailed to parent/guardian. Three out of the five youth's medications were continued from previous facility with no lapse in medication management noted.

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

All medications and sharps were observed to be secured and inaccessible to youth. Sharps are stored in secured cabinets in the clinic. Active over-the-counter (OTC) and prescription medications are stored separately. Medications such as oral, topical, and drops are separated by medication type. The program has a refrigerator in the clinic designated for medication requiring refrigeration. The medication delivery area is clean and organized. The area designated to store controlled medications is secured behind two locks. Expired or discontinued medications are returned to the pharmacy or destroyed by two registered nurses.

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

The program has only youth specific over-the-counter (OTC) medications. Perpetual inventory with running balances are maintained on all controlled substances with a shift-to-shift inventory. Syringes and sharps use a perpetual inventory which are counted whenever inventory is used and at least weekly. There were three randomly selected sharps selected for inventory and the

count matched the inventory sheet. Three youth medications were reviewed for inventory with no discrepancies found. There are no bulk over-the-counter (OTC) medications.

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

The program has a written policy and procedures regarding controlled medication inventory. The policy includes shift-to-shift inventory procedures. Shift-to-shift counts are documented for controlled medication. Three randomly selected controlled medication counts were observed. The physical inventory matched the documented inventory. Inventory documentation for the past six months was reviewed with no discrepancies.

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

Seven youth individual healthcare records (IHCRs) were reviewed, and all have a current Medication Administration Record (MAR). The program uses the standard Department MAR form. The MAR contained all elements required. For youth taking medication at admission, the initial MAR matched the medication list. Staff and youth initial each administered medication entry. There were no lapses or errors in medication administration. At a minimum, the nursing staff document weekly side effect monitoring on the MAR.

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

Medication administration was observed and occurred as scheduled. Medication delivery and supervision was the responsibility of the nurse during the time of administration. The working space was clean and organized, the nurse had control of the medications, and there was a structured process for the youth to approach the nurse. The youth are escorted one at a time to medication pass window. The Five Rights of Medication Administration are verified for each youth. The nurse discusses with the youth regarding any medication side effects. Staff observed to ensure the medication was swallowed. There were no youth requiring parenteral medication during the review. Seven youth were interviewed, and all stated the nurse gives youth their medication. Seven staff were interviewed, and all stated the nurse gives youth their medication. Six staff also stated a supervisor can give a youth medication.

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

The program has a policy and procedures for medication administration when no nurse is on-site. Trained non-healthcare staff are permitted to assist in the delivery of oral medication, prescribed and over-the-counter, in the absence of a licensed healthcare professional. The staff member assisting youth with the self-administration of medication is not permitted to conduct or supervise any facility activities during this time. Both the staff and the youth initial the Medication Administration Record (MAR). Non-healthcare staff are trained by the director of nursing. Seven youth were interviewed, and all stated the nurse gives their medication. One youth stated they are provided medication in the evening from the supervisor. Seven staff were interviewed, and all stated the nurse gives youth their medication. Seven staff also stated a supervisor can assist youth with self-administration of medication.

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.	

Seven youth individual healthcare records were reviewed. Four youth records were applicable for youth prescribed psychotropic medications while at the program. One youth was on psychotropic medication upon admission to the program. Three youth were prescribed psychotropic medications subsequent to their admission to the program. Two additional youth records were reviewed for youth admitted to the program on psychotropic medication. For those three youth, there was documentation designated health authority (DHA) and psychiatrist were notified upon the youth's admission. For each youth, the psychotropic medications were continued to be administered until an initial diagnostic psychiatric interview was conducted. Each initial diagnostic psychiatric interview was conducted within fourteen days of the youth's admission into the program. Each youth had a monthly Clinical Psychotropic Progress Note (CPPN) continuing the youth on the psychotropic medication. There are no standing orders or emergency treatment orders for psychotropic medications.

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

The program has a policy and procedures in place for infection control to utilize all available interventions to prevent and minimize the spread of disease among youth and staff. Universal Precautions are included in the Comprehensive Education and Prevention Plan at the program. Hepatitis B immunizations are available to staff, if necessary, at no cost. Staff have access to protective equipment. There were no instances in which the local Department of Health and/or the Center for Disease Control (CDC) were required to be notified.

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

The program's comprehensive Infection Control Plan includes training for all staff and youth. Seven staff pre-service and seven in-service training records reviewed documented all staff received training on infection control. Seven youth individual healthcare records were reviewed for infection control education and all had documentation the youth received education on prevention and transmission of communicable disease, vaccinations, and Center for Disease Control (CDC) guidelines for infection control.

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 written Exposure Control Plan available to all employees. The plan is reviewed and signed annually by the facility administrator (FA), director of nursing, and designated health authority. The program has not had any incidents requiring them to notify the local county Department of Health or the Center for Disease Control (CDC). Seven staff pre-service and seven in-service training records reviewed documented all staff received training on the program's Exposure Control Plan. An interview with the FA indicated the program's Exposure Control Plan is in the administration lobby and in the medical clinic. The FA confirmed the program conducts annual training on the Exposure Control Plan.

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 a 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 a 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 a male program; therefore, this indicator rates as non-applicable.

Standard 5: Safety and Security

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

The program has a policy and procedures regarding active supervision. Program staff to youth ratios are one to eight during day time activities and one to twelve during sleeping periods. Over the course of the four-day review, observations of supervision were made each day. Staff were observed supervising youth during school, transitions, and during after school activities. Staff were observed in compliance with ratio requirements. At one point, a youth was observed going out the backdoor of the education building as a staff stood in a classroom door watching. A supervisor, upon seeing this, instructed the youth to get back inside. During video review of supervision while youth are sleeping, a staff supervising a dorm on her own, was observed putting her head down on a desk and closing her eyes for approximately four minutes.
The program has a full schedule of activities planned and youth were observed engaged in the activities not just sitting around. The daily schedule was posted in each dorm. Staff accounted for youth under their supervision at all times. Staff were observed escorting youth from one location to another; not letting youth roam free. Positive interactions between staff and youth were observed, and staff were observed applying the behavior management system consistently. During informal interviews, staff members were able to immediately account for the youth they were supervising without the need to count the youth. If the count is not reconciled, the supervisor is notified, youth movement stops, and a recount is conducted.

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

The program has a detailed written behavior management system (BMS). The BMS is posted and included in the youth handbook which each youth receives and reviews at orientation. Rules governing conduct and positive and negative consequences for behaviors are included in the youth handbook. The BMS includes the following: maintaining order and security, promoting and protecting youth rights, positive and negative consequences, constructive disciplinary actions, opportunities for positive reinforcement, recognition of accomplishments and positive behaviors at a four to one ratio, promoting socially acceptable means for youth to meet their needs, process for explaining to youth the reason for any sanction imposed, an opportunity for youth to explain their behavior, opportunity for staff and youth to discuss the impact on others, reasonable reparations for harm caused to others, discussion of alternative behaviors, promotion of positive dialogue and peaceful conflict resolution. Additionally, the separation of youth from the population is minimized. The BMS further addresses negative consequences are in direct relation to the severity or seriousness of the inappropriate behavior exhibited, and a

variety of rewards and incentives can be earned. Seven staff were interviewed, all explained the program uses a point system and were able to explain how the BMS is implemented. Staff also gave examples of incentives offered which include: outings, movies, ice cream, games, and bi-weekly canteen. Four staff stated things cannot be taken away from youth as a consequence; the three staff who stated consequences included privileges can be taken away such as outings. Seven youth were interviewed and all were able to explain the program's point system and how through earning points and making their days they can level up. All seven were also able to list rewards used such as movies, outings, and snacks. The program director was interviewed, and he confirmed the program uses a point system. Additionally, he indicated rewards are monitored on a daily tracker which shows if a youth made his day, made nightly privilege and points accumulated for the day.

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

The program's Behavior Management System (BMS) includes protocol where staff are provided feedback regarding their implementation of the BMS. Position descriptions were reviewed which specify required qualifications of staff whose job functions include implementation of the BMS. The program's BMS includes a process in which staff explain to the youth the reason for any sanction imposed, the youth is given an opportunity to explain his behavior, and staff and youth discuss the behavior's impact on others, reasonable reparations for harm caused to others, and alternative acceptable behavior. The program does not use room restriction. Furthermore, the BMS does not include increased length of stay, denial of basic human rights or services, promotion of group punishment, punishment of youth by other youth, or disciplinary confinement. Seven staff were reviewed for completion of BMS training as a part of pre-service training and all seven had the required training. Seven staff were interviewed regarding how supervisors provide feedback to staff regarding the implementation of the BMS. They indicated it is reviewed at shift change and supervisors encourage staff to be firm and consistent; through monthly meetings, new information is shared at shift briefings, and throughout the day if something is written which is not valid, the supervisor will retrain staff; one to one discussions, and three staff also indicated supervisors are supportive of staff's implementation of the BMS. Seven youth were interviewed. All seven said youth are not allowed to punish other youth. All seven also indicated staff are consistent in their use of rewards stating there is no favoritism and staff treat all youth fairly. Three youth rated the BMS as fair, three as good, and one as very good.

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

The program has twenty-nine cameras, and all are operational. The program has six dorms which are open bay and monitored with two cameras in each dorm. Video recordings are stored for thirty days. Checks are documented in eight-minute intervals. Video recordings were reviewed for each dorm including second and third shift. The video recordings revealed staff are positioned to be able to observe youth sleeping. There was not a time observed where more than ten minutes passed without the staff actively observing the youth. Seven staff were interviewed, and two indicated room checks are completed every ten minutes, one indicated every eight minutes, and the remaining stated staff are always present, and youth are always being observed.

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

The program has a policy and procedures regarding census, counts, and tracking. Over the four-day annual compliance review counts were observed being conducted throughout the shifts. Documentation in the logbooks reflected counts were logged at the beginning of each shift, after outdoor activities, and at other times as called for. Seven staff were interviewed and asked how and when are youth counts conducted and what happens when there is a discrepancy. All indicated counts are conducted at a minimum of three times per shift. When there is a discrepancy staff indicated movement is stopped and there is a recount.

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's shift supervisors are responsible for maintaining the logbook during their shift. The logbook was observed to be bound with numbered pages. All entries were made in ink with no erasures or white out areas. No logbook entries were obliterated or removed. All entries included the date and time of the event, with the name of the staff and youth involved, and a brief description of the event. The shift supervisor documents their review of the logbook in the logbooks when assuming responsibility. The shift supervisor summarizes the events of their shift in the logbook at the end of their shift. The program documents emergency situations, special instructions for supervision and monitoring youth, population counts at the beginning and end of each shift, and any other population counts conducted, security checks conducted by staff, transports away from the facility, admissions, and internal incidents reported to the Florida Abuse Hotline of the Central Communications Center (CCC).

5.07 Key Control	Satisfactory Compliance
The program has a system in place to govern the control and use of keys including the following: • *Key assignment and usage including restrictions on usage* • *Inventory and tracking of keys* • *Secure storage of keys not in use* • *Procedures addressing missing or lost keys* • *Reporting and replacement of damaged keys*	

The program has a policy and procedures regarding key control which includes 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, and reporting and replacement of damaged keys. The keys are stored in a locked box within a locked cabinet in the shift supervisor office. The shift supervisor is responsible for assigning keys. The key inventory was reviewed and matched the actual key rings in use. The program tracks the keys in use by using a form on which staff indicate the date, time, which key they are assigned, and if they turned in their personal keys. The shift supervisor then initials the form is correct. At the end of the shift the form is completed to indicate the date and time the keys are returned. On the day the form was reviewed one staff had not indicated if he turned in his personal keys, upon question he indicated he had turned them in. A random check of three staff for personal keys was completed and reflected they all had turned in their personal keys. Seven staff were interviewed regarding the key control process. All staff indicated personal keys are securely stored, and program keys are assigned to staff. Additionally, six indicated there is daily tracking of keys through the key log, two referenced the inventory of keys, one stated youth do not have access to keys, and two stated if a key is missing the facility is searched. Three indicated damaged keys go through maintenance to be replaced.

5.08 Contraband Procedure	Satisfactory Compliance

The program shall develop and implement a system to prevent the introduction of contraband into the program.

A residential commitment program shall delineate items and materials considered contraband when found in the possession of youth. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its youth.

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

The program has a policy and procedures regarding contraband which aligns with the Department's recommended guidelines for contraband. The program defines items and materials considered contraband as well as exemptions. The policy and procedures address any employee found in possession of contraband will be subject to disciplinary action up to and including dismissal. The prohibited list includes illegal items, sharps, escape paraphernalia, drugs, tobacco products, cash, personal cell phones and or equipment or electronic devices capable of taking pictures or recordings. During orientation youth are provided with a list of contraband and are informed of consequences if found with contraband. Documentation was reviewed reflecting searches of the physical plant, facility grounds, and youth are conducted to prevent the introduction of contraband. The program documents the confiscation of contraband and the disposition. There were no instances of illegal contraband being discovered. The program director was interviewed and indicated all contraband found is given to the supervisor on duty who then passes it along to the assistant facility administrator or the program director who at then contacts the Central Communication Center (CCC), if needed.

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.

Over the course of the four-day annual compliance review, searches were observed occurring at various times to include before and after groups, after transports, during admission, after education and when transitioning class to class. The searches were conducted by the appropriate number of staff and the same gender as the youth. Documentation reflected youth are given a full body visual search after visitation. Youth were treated with dignity and respect to minimize the youth's stress and embarrassment during the process; staff also provided instructions to the youth during the search and explained the reason and extent of the search. Seven staff were interviewed and indicated searches occur every time there is movement, after meals, leaving dormitories, if suspected of contraband, and when youth return from off campus or family visitation they are given a full body visual search. Seven youth were interviewed regarding when searches occur. Each youth reported when returning from off campus, after

visitation, and after meals. Additionally, six youth reported after outdoor activities, when items are missing, and after work detail.

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 three vans. Currently, one is out of service due to the annual inspection revealing it needs new tires. This van has not been used to transport youth. All three vehicles received annual safety inspection and except for the van which is not being used for transports due to issues identified during the inspection deficiencies have been corrected. Vehicles used for transport were observed to have the appropriate number of seat belts, a seat belt cutter, a window punch, and a fire extinguisher. Each van is also assigned a first aid kit which is stored inside near the van keys. Two vans were checked out (one was used by staff attending training and another was used to transport a youth to the dentist) neither took the assigned first aid kit. A youth was observed returning from transport and was using a seatbelt. Vehicles were secured at all times.

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 policy which meets all requirements outlined by the Department relating to transportation of youth and driver eligibility. A cellular phone is issued to transporter. A one to five staff to youth ratio during all transports. A transport of one youth to the dentist was observed. Two staff accompanied the youth and they were both the same gender as the youth. A random check of personal and facility vehicles reflected they are locked when not in use. Youth and staff were observed wearing seatbelts and the youth was not attached to any part of the vehicle by any means other than the proper use of the seatbelt. The program maintains a list of approved drivers which ensures those operating the program vehicles have a current driver's license. Staff do not leave youth unsupervised in vehicles and youth are not permitted to drive program or staff vehicles. Seven staff were interviewed and all indicated they are issued a cell phone for transports; two also indicated they also have their radios. All seven staff also stated staff are not allowed to use personal vehicles to transport youth.

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

The program has a policy and procedures which outlines the weekly safety and security audit process. The policy outlines who is responsible for conducting the audits, the development and implementation of corrective actions warranted as a result of safety and security deficiencies found during any internal or external review, audit, or inspection, and an internal system to verify the deficiencies are corrected and existing systems are improved, or new systems are instituted as needed to maintain compliance. Documentation of weekly safety audits for the past six months was reviewed. Each week the safety and security audits were completed by administration and deficiencies as well as corrective action taken were noted. The program director was interviewed regarding deficiencies to which he stated a copy of the deficiency report showing what deficiencies are documented is given to the department manager. The program director and the department manager then meet to discuss action steps which will be followed to have the deficiency closed out.

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

The program has a policy and procedures which addresses the issuance, inventory, and control of equipment and tools. Tools were observed securely stored in a locked maintenance building. All tools were marked for easy identification. Documentation reflected tools were inventoried prior to being issued for work and following work activities. Sharp-edge or pointed tools were inventoried daily, except on days not used. A monthly inventory of tools which do not have sharp edges or points is also maintained. There were no machetes, bowie knives, or other long blade knives. There were no reports of missing or lost tools in the past six months. Training documentation reflected staff and youth are trained on the intended and safe use of tools. Seven staff were interviewed. All seven staff stated they are only allowed to use mops, brooms, and scrub brushes. Three staff did state youth in the Home Builder's Institute are allowed to use additional tools.

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

The program has a policy and procedures for the supervision requirements when youth use tools. The procedure indicates prior to a youth being issued tools a risk assessment must be completed to determine the youth's risk to self and others. Staff to youth ratios during activities involving tools is one to five. Seven youth records were reviewed, and each contained a risk assessment identifying youth who may use tools. Seven staff were interviewed regarding which tools youth are permitted to use. Seven indicated scrub brushes, mops, and brooms. Three staff also reported those youth in the Home Builders Institute (HBI) are permitted to use some additional tools with supervision. Seven youth were interviewed regarding which tools they are permitted to use. Seven reported scrub brushes, mops, and brooms. Four reported rakes. Three youth stated HBI youth may use additional tools.

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

The program has a policy and procedures which addresses outside contractors. The sign-in/instruction sheets for outside contractors were reviewed. The guidelines include tools will be checked upon arrival and departure, tool restriction while in the facility, youth are restricted from the work area, and missing tool follow-up if needed. Project invoices submitted to the program by the vendor were reviewed and compared to the sign-in sheets. Documentation supported the program inventoried the tools or equipment when the vendor arrived and left.

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 conducts practice drills and is prepared for immediate implementation or mobilization of the plans whenever an emergency or disaster situation necessitates. The program's documentation reflected fire drills are conducted monthly on each shift. The program also conducts safety, evacuation, and disaster drills. The Continuity of Operations Plan (COOP) indicates disaster drills should be conducted quarterly for each shift. Documentation reflected the drill was conducted on first shift and then reviewed with second and third shift ensuring all staff members know how to respond. Fire evacuation routes and egress plans were posted throughout the facility. The program director confirmed fire drills are conducted on each shift monthly and disaster and emergency drills are conducted quarterly. Seven staff were interviewed regarding the drills they have participated in within the last twelve months. Seven stated fire drills, four weather drills, one major disturbance, two bomb threats, one hostage situation, two chemical spills, one terrorism, and three escape drills. Seven youth were interviewed and all reported they have been instructed on what to do in case of a fire. Two youth indicated fire drills are done weekly, one said bi-weekly, and four said monthly.

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 Continuity of Operations Plan (COOP) is available in the program director's office and the shift supervisor's office. In these locations the plan is readily available to staff. The COOP was reviewed August 18, 2018 and approved by the Department's Regional Director on September 4, 2018. The program maintains equipment and supplies required for continuous operation and services during emergency or disaster situations. The program director confirmed the location of the COOP. The program's COOP includes the following: fire and fire prevention and evacuation, severe weather, disturbance or riots, bomb threats, hostage situations, chemical spills, flooding, terrorist threats or acts, staff roles and responsibilities, any equipment and supplies needed, information about youth which may be needed, alternative housing arrangements, provisions for continuity of care and custody of youth, and provisions for public protection.

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

The program has a policy and procedures regarding the storage and inventory of flammable, poisonous, and toxic items and materials. Observations reflected flammable, poisonous, and toxic items were secured at all times. These items are stored in areas inaccessible to youth. Inventories for all flammable, poisonous, and toxic items were reviewed and were accurate. There were no items missing from the inventory. The inventory matched the actual items within the program. The program also has a Safety Data Sheet (SDS) maintained on-site for all materials. In each dormitory, cleaning chemicals are stored in a locked area which staff have access to. Additional chemicals, and other flammable, poisonous, or toxic items are stored in the maintenance building in a locked cabinet which the plant manager has access to.

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

The program has a policy and procedure which addresses youth handling and supervision of flammable, poisonous, toxic items and materials. The policy states youth are prohibited from using and possessing these items at the program. The program maintains strict control of flammable, poisonous, and toxic items and materials. Youth do not use, handle, clean-up dangerous or hazardous chemicals. Youth also do not clean, handle, or dispose of any person's bio-hazardous material, bodily fluids, or human waste. There is restricted youth access to areas where items are being stored. Seven youth were interviewed, and all confirmed they do not handle any chemicals or cleaning products.

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

The program has a policy and procedures for the disposal of flammable, toxic, caustic, and poisonous items. The plant manager is responsible for disposing of these items. Disposal procedures are in accordance with Occupational Safety and Health Administration (OSHA) Standards. Maintenance personnel stated he takes the items for disposal to the Northwest Solid Waste Management Facility. Hazardous liquid waste is disposed of in accordance with the Safety Data Sheet. Hazardous liquid waste is stored in a hazardous materials storage area until disposal. Liquid waste from work details is disposed of in the plumbing drains. Kitchen liquid waste, except grease, is disposed of in the kitchen. Grease is placed in a separate container for disposal. The program director confirmed the disposal procedures for flammable, toxic, caustic, and poisonous items.

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

The program's policy and procedures provide for activities based on the developmental levels and needs of the youth in the program. The program has an activity schedule which reflects a range of supervised and structured indoor and outdoor recreation and leisure activities for the youth. The logbook confirmed activities occur as scheduled. Activities include a choice of leisure and recreation options and youth are encouraged to explore their interests. Youth were observed engaged in constructive use of leisure time. Activities for the youth promote social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. The program has a recreational therapist with the required qualifications. The program also has a formal process to promote constructive input by youth through a student council which meets bi-weekly. Seven staff were interviewed and listed the following recreation and leisure activities are available: basketball, volleyball, soccer, frisbee, and kickball. Seven youth were interviewed, and all said they have an hour of physical activity each day. Youth listed the following examples of activities: basketball, kickball, volleyball, and soccer.

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 utilize water activities; therefore, this indicator is not applicable.

5.23 Visitation and Communication	Satisfactory Compliance

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

The program has a policy and procedure related to visitation, youth correspondence, and telephone use. The visitation schedule was observed posted. The visitation log was also reviewed which confirmed visitation occurs on Sundays. The program's policy provides weekday visitation is available to help parents who are unable to come on the weekend, but this must be arranged and preapproved by the assistant facility administrator and the clinical director. Youth are also given one ten-minute call a week to immediate family. Mail is distributed and collected daily. Seven youth were interviewed, and all indicated they have had the opportunity to communicate with family members by mail, telephone, or at visitation.

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

The program does not utilize controlled observation; therefore, this indicator is not 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 observation; therefore, this indicator is not 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 observation; therefore, this indicator is not applicable.

Program Name: Brooksville Academy
Provider Name: Youth Opportunity Investments, LLC
Location: Hernando County / Circuit 5
Review Date(s): May 7-10, 2019

MQI Program Code: 1445
Contract Number: 10208
Number of Beds: 60
Lead Reviewer Code: 143

Overall Rating Summary

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

Limited Ratings	Failed Ratings
3.03 Non-Licensed MH/SA Clinical Staff	