STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Broward Youth Treatment Center

Youth Opportunity Investment, LLC

(Contract Provider)
8301 South Palm Drive, Building # 2
Pembroke Pines, , Florida 33025

Review Date(s): November 3-6, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Gabriel Medina , Office of Accountability and Program Support, Lead Reviewer (Standard 3)
Camelia Daley, Office of Accountability and Program Support, Regional Monitor (Standard 1)
Rosa Flores, Office of Accountability and Program Support, Regional Monitor (Interviews)
Rondarrell George, Office of Accountability and Program Support, Regional Monitor (Standard 5)
Peter Keelan, Office of Education, South East Region Education Coordinator (Standard 2)
Gary Mogan, Office of Accountability and Program Support, Regional Monitor (Interviews)
Maryann Sanders, Office of Accountability and Program Support, Deputy Regional Supervisor (Standard 4)
Sharon Wong, Office of Accountability and Program Support, Regional Monitor (Standard 2)

Program Name: Broward Youth Treatment Center
Provider Name: Youth Opportunity Investment, LLC.
Location: Broward County / Circuit 17
Review Date(s): November 3-6, 2020

MQI Program Code: 1269
Contract Number: 10553
Number of Beds: 40
Lead Reviewer Code: 50

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

Overall Rating Summary

Overall Rating Summary
All indicators have been rated Satisfactory and no corrective action is needed at this time.

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Youth Supervision *	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	Ten Minute Checks *	Satisfactory
5.05	Census, Counts, and Tracking	Satisfactory
5.06	Logbook Entries and Shift Report Review	Satisfactory
5.07	Key Control*	Satisfactory
5.08	Contraband Procedure	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	Vehicles and Maintenance	Satisfactory
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Satisfactory
5.13	Tool Inventory and Management	Satisfactory
5.14	Youth Tool Handling and Supervision	Satisfactory
5.15	Outside Contractors	Satisfactory
5.16	Fire, Safety, and Evacuation Drills	Satisfactory
5.17	Disaster and Continuity of Operations Planning (COOP)	Satisfactory
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.19	Youth Handling and Supervision of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.20	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.21	Elements of the Water Safety Plan, Staff Training, and Swim Test *	Non-Applicable
5.22	Visitation and Communication	Satisfactory
5.23	Search and Inspection of Controlled Observation Room	Non-Applicable
5.24	Controlled Observation	Non-Applicable
5.25	Controlled Observation Safety Checks and Release Procedures	Non-Applicable

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Program Overview

The Broward Youth Treatment Center is a forty-bed, non-secure residential commitment program, for thirteen to eighteen-year-old males, located in Pembroke Pines, Florida. The program is operated by Youth Opportunity Investments, LLC., through a contract with the Department. The program provides substance abuse treatment overlay services (SAOS), including substance abuse assessments, evaluations, individualized substance abuse treatment planning, daily substance abuse services including individual, group, and family substance abuse counseling, crisis intervention therapy, suicide prevention services, mental health and substance abuse treatment for youth with co-occurring mental disorder, twenty-four-hour response capability, routine and random urinalysis, psychopharmacological therapy, and psychiatric and psychological services. In addition, the program fosters each youth by providing weekly group therapy services to include Skillstreaming the Adolescent, Living in Balance (LIB), Seeking Safety, Mindfulness for Addiction, Stop the Chaos, Talks my Father Never Had With Me, Men's Trauma, Thinking for a Change, and Impact of Crime, coupled with gender-specific interventions. The program administration is comprised of a facility administrator (FA), one assistant facility administrator (AFA) (position currently vacant), a clinical director, and a human resources/business manager. Case management services are provided by a director of case management, three case managers, and one transition services manager. Mental health and substance abuse staff at the program include a designated mental health clinician authority (DMHCA) who supervises three non-licensed therapists. In addition, the program contracts with licensed psychiatrist for the provision of psychiatric services to all applicable youth. Medical services are offered seven days a week and are provided by a licensed designated health authority (DHA), one health service administrator/registered nurse (RN), and one registered nurse (RN). Educational services, including vocational training courses, are provided by the Broward County School District. The layout of the program includes one main building with hallways on each wing of the structure. Youth rooms are located on the east wing. Staff offices are in areas which are secured and inaccessible to youth. All meals are prepared on-site. The program has fifty-eight security cameras providing coverage with the capability to store video for up to thirty-days. All cameras were operational at the time of the annual compliance review. The program utilizes a trauma-informed care approach, taking into consideration the unique population of males with a history of substance abuse. Due to the COVID-19 pandemic, all the program's youth and staff are required to wear masks, and the program implemented cleaning and sanitation plans to reduce the risk of spreading or contaminating surfaces, and temporary ceased, change, or limited face-to-face visitations, Family Day programing, outings such as community projects, home-passes, Community Advisory Board meetings, some school activities, guest speakers, volunteers, interns, vocational services, and Standardized Program Evaluation Protocol (SPEP) due to low enrollment youth counts. At the time of the annual compliance review, the program had four vacant positions including three safety and security specialists and the AFA.

Standard 1: Management Accountability

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

The program has a written policy and procedures in place to ensure all newly hired staff, volunteers, and interns receive an initial background screening prior to unsupervised contact with youth. The program had thirteen new staff hired since the last annual compliance review. A review of background screenings verified each staff received an initial background screening completed by the Department's Background Screening Unit (BSU)/Clearinghouse prior to contact with youth or access to confidential records. A review of records reflected each new direct-care staff completed a pre-employee eligibility assessment and received a passing score. Reviewed documentation confirmed the program reviewed the Department's Central Communications Center (CCC) person involvement history report, the Staff Verification System (SVS), and the Florida Department of Law Enforcement (FDLE) results for each new staff prior to hiring. The Annual Affidavit of Compliance with Level 2 Screening Standards was signed and submitted to the Department's Background Screening Unit (BSU) on March 3, 2020, meeting the annual requirement. The Department of Education submitted an annual screening on February 28, 2020 to the Department's BSU, meeting the annual requirement.

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 written policy and procedures to ensure all staff, volunteers, and interns receive a background rescreening every five years from the initial hire date. The program submits information to the Department's Background Screening Unit (BSU)/Clearinghouse at least ten days prior to the staff's anniversary date. There were no staff eligible for a five-year background rescreening at the time of the annual compliance review. There were no volunteers, mentors, or interns who were applicable for a 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.

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

The program has a written policy and procedures addressing each youth's rights to ensure an abuse-free environment. The facility operating procedures (FOPs) for abuse and neglect reporting, along with the program's manual, addresses the code of ethics. Staff are required to sign the manual acknowledgment form indicating they reviewed the required information. Five reviewed staff personnel records reflected all staff reviewed the program's code of ethics and signed the acknowledgement form. The program completed a Trauma Responsive and Caring Environment (TRACE) Self-Assessment on July 6, 2020.The Florida Abuse Hotline and the Department's Central Communications Center (CCC) telephone numbers were observed to be posted throughout the program. The program's policy outlines the reporting procedures for all staff to follow when a youth requests to report abuse. A telephone located in the main hallway and cafeteria has been designated for youth to contact the Florida Abuse Hotline or the Department's CCC, if youth feel they have been abused or neglected. Staff are to notify the shift supervisor or master control if a youth requests access to the Florida Abuse Hotline or the Department's CCC, as appropriate. Youth are allowed to freely communicate with the Florida Abuse Hotline or the Department's CCC operator. Once the call has been completed, staff are to notify the shift supervisor or master control. A youth's refusal to make the abuse call themselves does not relieve the staff from their mandate to call the Florida Abuse Hotline, if the staff has reasonable suspicion abuse has occurred. There were three incidents reported to the CCC for physical abuse allegations since the last annual compliance review. One was substantiated by the program, resulting in a termination of the staff. The second report was substantiated by the program resulting in staff resigning in lieu of termination. The third report is currently pending closure justification, as the incident is currently still under investigation. There were no Prison Rape Elimination Act (PREA) investigations and no Office of the Inspector General (OIG) investigations pending at the time of the annual compliance review. Five youth were interviewed and stated they feel safe in the program and staff are respectful when talking to them. Five staff were interviewed and stated they have never heard a co-worker use profanity

when speaking to a youth and never observed a co-worker telling a youth they could not make an abuse call. The five interviewed staff explained the process for allowing staff and youth to call the Florida Abuse Hotline or the Department's CCC to report suspected abuse. An interview with the facility administrator (FA) regarding staff violations of the code of conduct indicated a staff's misconduct may lead to immediate suspension or termination.

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 written policy and procedures to ensure the program takes immediate action to address incidents of physical, psychological, and emotional abuse. The program had three incidents of alleged physical abuse toward a youth since the last annual compliance review. A review of the reports indicated the facility administrator (FA) took immediate action to address the concerns by removing the staff from youth contact until a determination has been made. The third incident is currently open while the Department of Children and Families (DCF) and local law enforcement pending investigation. An interview with the FA indicated staff and youth are knowledgeable of contacting the Florida Abuse Hotline or the Department's Central Communications Center (CCC). Staff receive training during the pre-service training process and reminded at all staff meetings, supervisor meetings, and annually regarding appropriate interactions with youth. Youth are advised of the abuse reporting process during orientation and signs are posted throughout the program.

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

The program has a written policy and procedures for reporting incidents into the Department's Central Communications Center (CCC). The program had fifty-three incidents reported to the CCC in the past six-months. A review of five CCC reports verified each incident was reported to the CCC within the required two-hour time frame and documented in the facility logbook and shift reports, as required. A review of the program's internal incident reports and youth grievances reflected no additional incidents which should have been reported to the CCC. An interview with the facility administrator (FA) indicated the incident reporting process is to contact an administrator as soon as staff or youth are aware of any incident. Administration will then contact the Department's CCC or the Florida Abuse Hotline within two hours of gaining knowledge of the incident. If a staff is involved, the staff is removed from youth contact or placed on administrative leave without pay pending the outcome of all investigations. The program maintains a separate file of all incident reports and has a system in place for tracking all incidents.

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 for the use of Protective Action Response (PAR) techniques by staff. The program had nineteen PAR incident reports during the last six-month period, of which five were reviewed. Documentation supported all five reports were completed by the end of the staff's workday and included all required written statements by each staff involved. All required reviews were conducted and documented by the supervisor on-duty at the time of the incident and by a PAR-certified supervisory staff member within the required time frames. All five PAR reports were reviewed within seventy-two hours of the incident by the facility administrator (FA) or designee. Each report reflected a post-PAR interview was conducted with each of the youth within thirty-minutes of the incident by the FA or designee to assess the need for further medical review. One of the five youth indicated the need for medical attention and was seen by nursing staff for a post-PAR medical review. Mechanical restraints were not used in any of the reviewed PAR incidents. The program's PAR plan was submitted and approved by the Department's Office of Staff Development and Training on January 10, 2019. Reviewed documentation validated the completion of monthly PAR reports. The program's PAR rate during the annual compliance review period was 3.13, which is above the statewide Residential PAR rate of 2.23.

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

The program has a policy and procedures addressing pre-service training. The program maintains a pre-service training plan and calendar for all new staff which was submitted to the Department's Office of Staff Development and Training on January 19, 2019 and approved on February 7, 2019. Pre-service training is provided through a combination of instructor-led, web-based courses, and on-the-job training. Five staff training records were reviewed for pre-service training. All five records reflected staff completed the certification process within 180 days of hire and completed all required trainings inclusive of Protective Action Response (PAR), first-aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), professionalism and ethics, suicide prevention, emergency procedures, child abuse reporting, Human Trafficking, and Prison Rape Elimination Act (PREA) prior to having any contact with youth. A review of all five staff training records contained documentation to support each staff exceeded the required 120 hours of pre-service training. All contractually required trainings were completed for all five staff reviewed. Documentation confirmed all training was delivered by qualified trainers and documented in the Department's Learning Management System (SkillPro) within thirty days of training completion.

1.08 In-Service Training	Satisfactory Compliance

Residential contracted provider staff complete twenty-four hours of in-service training, including mandatory topics specified in Florida Administrative Code, each calendar year, effective the year after pre-service/certification training is completed.

Supervisory staff completes eight hours of training (as part of the twenty-four hours of annual in-service training) in the areas specified in Florida Administrative Code.

The program maintains a written in-service training plan which was submitted to the Department's Office of Staff Development and Training on January 19, 2019 and approved on February 7, 2019. According to the program's contractual requirements, specific training is required for different position classifications such as management, case managers, mental health, and direct care staff. An informal interview with the facility administrator (FA) indicated youth care workers are Protective Action Response (PAR) certified direct-care positions and included in the staff-to-youth ratio. All supervisors, the assistant facility administrator (AFA), medical staff, mental health staff, case management staff, maintenance staff, and kitchen staff are PAR certified and are qualified to supervise youth in special circumstances; however, are not included in ratio. Five staff training records, of which two were supervisor's training records, were reviewed for in-service training. Each reviewed staff training record documented each staff exceeded the twenty-four hours of in-service training requirements. Each staff had current certifications in first-aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and Protective Action Response (PAR). Each staff completed training in professionalism and ethics, including standards of conduct, suicide prevention, and annual active shooter training. All five staff records documented staff completed the required annual human trafficking training. Each reviewed record further verified completed training in suicide prevention, ethics, communications skills, professionalism, as well as the contract required training elements of stress management, restorative justice, universal precautions, and behavior management. Two of the five staff records reviewed were supervisor training records and confirmed the completion of eight hours of management and supervisory training inclusive of management, leadership, personal accountability, employee relations, communications skills, and fiscal. Reviewed documentation supported each supervisor exceeded this requirement. All trainings were delivered by qualified trainers and documented in the Department's Learning System (SkillPro) within thirty days of training completion.

1.09 Grievance Process	Satisfactory Compliance

Program staff shall be trained on the program's youth grievance process and procedures. The program adheres to their grievance process and shall ensure it is explained to youth during orientation and grievance forms are available throughout the facility.

Completed grievances shall be maintained by the program for a minimum of twelve months.

The program has a policy and procedures outlining the grievance process for the youth to formally file complaints regarding conditions, treatment, services, and the actions of program staff and other youth which are in violation of the youth's rights. The policy ensures complaints are reviewed in a fair and expeditious manner and are resolved in the best interest of the youth, the program, and the Department. The grievance process includes informal, formal, and appeal phases. The policy indicates youth are encouraged to resolve questions, disputes, or complaints through informal communication with program staff. Staff are required to make a reasonable effort to assist the youth with their concerns. The requests are typically resolved within twenty-

four hours, but no later than seventy-two hours after submission. If a youth is not satisfied with the outcome of the informal complaint or feel the concern is more serious, the youth can complete a formal grievance form. The informal and formal grievance forms were available in the youth dormitory areas. The program requires formal grievances be processed by the program's grievance officer, the assistant facility administrator (AFA) or designee, within seventy-two hours of submission. If the grievance is unable to be resolved with the youth, the grievance enters the appeal phase. The facility administrator (FA) will address all appeals within seventy-two hours of the formal decision. There were no grievances submitted during the annual compliance review period; however, the grievance box is checked each day by the AFA or designee, who will attempt to resolve the concern as soon as possible.

1.10 Interventions and Facilitator Training	**Satisfactory Compliance**
The program shall implement interventions for each youth. Interventions shall include, but are not limited to, evidence-based practices, promising practices, or practices with demonstrated effectiveness. Staff whose regularly assigned job duties include the implementation of a specific intervention and/or curriculum must receive training in its effective implementation.	

The program utilizes Impact of Crime (IOC), Thinking for a Change (T4C), and Living in Balance (LIB) as the curricula provided to youth in the program. The program has three clinical staff who facilitated LIB and two case managers who facilitated IOC, and one case manager who facilitated T4C during the annual compliance review period. A review of training documentation found each staff was trained by a qualified trainer, to deliver the respective curricula. Each clinical staff holds at a minimum of a bachelor's-level degree and non-clinical staff hold a high school diploma. A review of sign-in sheets, video recordings, and the program's schedule, found each of these groups was offered as indicated on the program's schedule. A review of five youth case management records found all five youth participated in IOC, T4C, and LIB. An interview with the facility administrator (FA) confirmed these services were conducted to address the needs of the youth, as identified through screenings conducted during admission. All five interviewed youth indicated they participated in one of the interventions offered by the program.

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

The program maintains a policy and procedures which ensure interventions or instruction focusing on developing life and social skill competencies in youth, are provided. The program's treatment services target life and social skills interventions which address identification and avoidance of high-risk situations, communication, interpersonal relationships, anger management, and problem solving. The program identifies youth in need of services by reviewing the risk and criminogenic needs. Life skills training is provided utilizing Living in Balance. A review of the program's activity schedule, handouts, and group sign-in sheets verified groups were held, as required. A majority of the youth's time is spent in structured, therapeutic activities with a minimum of one hour of each day devoted to the delivery of treatment services targeted to address identified risk, criminogenic behaviors, and treatment needs. The program has of six staff trained to provide service delivery. A review of five youth case management and mental health records confirmed each youth received services, as outlined in the performance and treatment plans.

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 provides a curriculum which assists the youth to accept responsibility for the harm their criminal actions have caused in the community. An interview with the designated mental health clinician authority (DMHCA) indicated the program utilizes the Impact of Crime (IOC) curriculum where youth are exposed to victim's statements by way of video tape, written material, and victim speakers to learn of the impact of being a victim of crime. Youth participate in on-site and off-site community service work projects to become more aware of the harm they caused. Group sessions are held on Tuesdays and Thursdays by staff trained to provide the service. A review of five youth performance plans and group sign-in sheets, coupled with the program's activity schedule, verified the practice of restorative justice philosophy. A review of video recordings of youth in IOC training was reviewed and indicated the instructor delivered the curriculum, as required. The program typically uses community service projects to enhance the lessons learned regarding restoring victims and their communities. These projects and opportunities for outside speakers, have been limited since March 2020, due to the COVID-19 pandemic and guidelines from the Centers for Disease Control and Prevention. A review of activities before the pandemic reflected regular community service outings and opportunities for the youth to serve others. An informal interview with the facility administrator (FA) revealed the next community service activity will resume in November 2020.

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

The program provides delinquency intervention and gender-specific treatment services for each youth in the program which demonstrates a component addressing the needs of a targeted gender group. An interview with the facility administrator (FA) and the designated mental health clinician authority (DMHCA) reflected when the program has applicable youth with trauma, a group cycle of Men's Trauma Recovery and Empowerment Model (M-TREM) is delivered. This intervention has a minimum number of youth required to initiate the intervention. The program designs its services based upon the common characteristics of male youth ages thirteen to eighteen years of age. The purpose for each group cycle is to assist the youth in identifying any underlining trauma and provide coping skills through group sessions. The program utilizes the Talks My Father Never Had with Me curriculum for young men who could benefit from a mentor or positive male role model. The FA confirmed group sessions are held on Mondays and Wednesdays and facilitated by trained staff. A review of group sign-in sheets and observations of video also confirmed groups were conducted, as required. A review of the curriculum and the program's activity schedule indicated each gender-specific programming is designed to target the needs of the youth in the program and groups are conducted as required.

1.14 Internal Alerts System and Alerts (JJIS) (Critical)	Satisfactory Compliance
The program shall maintain and use an internal alert system easily accessible to program staff and keeps them alerted about youth who are security or safety risks, and youth with health-related concerns, including food allergies and special diets. When risk factors or special needs are identified during or subsequent to the classification process, the program immediately enters this information into its internal alert system. The program ensures only appropriate staff may recommend downgrading or discontinuing a youth's alert status. *When risk factors or special needs are identified during or subsequent to the classification process, the program immediately enters this information into the Juvenile Justice Information System (JJIS). Upon recommendation from appropriate staff, JJIS alerts are downgraded or discontinued.*	

The program has a written policy and procedures for an internal alert system designed to inform staff of youth with health-related concerns, mental health concerns, and/or safety and security risks. The program maintains an on-going alert system to ensure information concerning a youth's special conditions, suicide risks, safety, and/or security risks are effectively communicated to staff in a manner which preserves the youth's privacy. Alerts are identified at the time of admission either through an interview with the youth and/or a review of supporting documentation within the admission packet. Alerts are then entered into the Department's Juvenile Justice Information System (JJIS) and added to the program's internal alert system. The internal alert lists are posted in master control and the briefing room which identifies security risks, mental health/clinical staff for suicide risks and other mental health alerts, medical for health conditions and medications, and the food service staff for dietary and allergies. Mental health clinical staff enter mental health alerts, including when the youth is added, removed, and/or stepped down from precautionary observation (PO). The medical alerts and food allergies, medical staff enters the alerts in JJIS and initiates the internal alert. The board is updated, as needed, by medical, clinical, and case management staff. Additionally, the program maintains a medical alert log which is updated when changes occur by nursing staff. A review of documentation and observations during the annual compliance review, confirmed the alert board and medical alert log were updated by the shift supervisor at each shift briefing for oncoming staff. Four of the five reviewed youth records, to include the youth's individual health care records, mental health and substance abuse records, and youth case management records, were applicable for alerts relating to mental health, suicide risk, medications, special diet, allergies, no strenuous activity, and gang member/gang association were entered and removed, when applicable, in JJIS. No discrepancies were identified when comparing the internal alert system with JJIS alerts for the four applicable reviewed youth. An interview with five staff indicated staff are informed of youth alerts including mental health, medical, and security alerts by the shift report, the grease board in master control, or the alert board in the conference room. There is a food allergy clip board in the meal preparation area. The program utilizes a color-coded process to identify each youth alert. Alerts are reviewed during the morning management team meetings and as necessary.

1.15 Youth Records (Healthcare and Management)	Satisfactory Compliance
The program maintains an official case record, labeled "Confidential," for each youth, which consists of two separate files: • *An individual healthcare record* • *An individual management record.*	

The program has a policy and procedures regarding the creation, maintenance, and storage of individual healthcare records, mental health and substance abuse records, and case management records for each youth at the program. Each of the five youth records reviewed were found labeled "Confidential" and were secured in the assigned locked offices and medical clinic which are inaccessible to youth. Observations of the records reflected each youth record had the required documentation. Records reviewed identified the youth's name, Department identification number, and date of birth. The case management records were labeled with additional youth information such as name, date of birth, committing offense, legal information, county of residence, and the assigned juvenile probation officer. In addition, the separate sections of the records were broken into demographic and chronological information, treatment team activities, correspondence, case management, and a miscellaneous sections.

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 regarding youth input. The program provides many avenues for youth to provide input about the program. The program has a student council and utilizes town hall meetings to promote a formal process for youth to have constructive input regarding the program. Student council members consist of a president, vice president, secretary, chairperson, and a treasurer who are chosen by way of a youth voting process along with input from staff. Student council meetings are held once a month and address issues initiated by the youth in the program. Town hall meetings are held once a month with the youth in the program to ensure all issues are addressed concerning the youth. During a town hall meeting, youth can communicate to a board member regarding a concern and the board member would then convey the concern to the student council meeting to be addressed. Agendas, sign-in sheets, and minutes are maintained in separate binders for both student council and town hall meetings. A review of the binders for the past six months verified meetings were held, as required. Four of the five interviewed youth indicated the program has a student council board for youth to provide input about what happens in the program. The fifth youth was unsure. An informal interview with the facility administrator (FA) confirmed the youth advisory board provides an opportunity for youth to take some ownership in strengthening the program while teaching problem solving, decision making, and teamwork.

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

The program established a community advisory board which meets quarterly to serve as a support to the program and a link to the community. The facility administrator (FA) solicits and maintains a collaborative partnership with the Department and local stakeholders in the community. Partnerships consist of letters of support, community service projects, participation in community board meetings, and public service events. The program provided documentation

reflecting correspondence soliciting active involvement of other interested community partners. Reviewed meeting agendas and minutes for the previous four quarters reflected consistent attendance by members of the business community, school board, and members of the faith community. An interview with FA indicated advisory board meetings are held quarterly at the program; however, due to the COVID-19 pandemic and in accordance with guidelines of the Centers for Disease Control and Prevention, meetings during the last two quarters were conducted by telephone. The board makes suggestions during the meetings, and sometimes meet with the student council to discuss what they would like to see different in the program and areas of possible improvement.

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

The program has a policy and procedures in place regarding program planning designed to establish a system of communication, facilitate staff involvement, discuss program issues, and the development of policies, procedures, and programs. The program solicits information from youth and parents/guardians utilizing surveys, which can be completed electronically through Survey Monkey or through completion of paper copies. Each youth's parent/guardian is sent an admission survey to complete after each youth's intake. The program utilizes the surveys to gather information regarding the program's admission process and customer service practices. Conversely, once a youth is discharged from the program, the parent/guardian for each youth is provided with a family satisfaction survey. The program incorporated a staff token system to recognize staff who demonstrate teamwork, leadership, and positive culture. Each time a staff is recognized, they are given a chip which is used to receive incentives provided by program management such as gift cards worth various denominations. Reviewed documentation reflected the program conducts monthly all-staff meetings, monthly supervisor meetings, and daily management meetings to share information with staff and to enhance program planning. Staff can communicate input and provide feedback on the program's operations during these meetings or at any given time with program's administrative staff. Documentation of all-staff meeting minutes confirmed the program reviews medical updates, mental health updates, drill reviews, policy reviews, human resources issues, and safety, security issues, and any applicable major issues with staff. Four of the five interviewed staff reported the communication at the program is very good and one reported communication as fair.

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

The program has a policy and procedures in place which outlines requirements for evaluating staff performance annually and upon completion of the first ninety-days of hire. A review of position descriptions confirmed job duties are clearly outlined for each staff member. Each staff was evaluated based on established performance standards outlined in the position descriptions which were received and signed upon hire. All required positions in the program's contract are maintained and performed, as required, based on the position descriptions and reviewed documentation. The human resource manager (HRM) and facility administrator (FA) confirmed evaluations are completed after the first ninety days of employment and annually thereafter. Staff annual performance factors are rated on a scale of one to four, with four indicating exceeding normal job requirements, three indicating meets normal job requirements, two indicating improvements are needed to meet job requirements, and one indicating failed to meet

job requirements. Acceptable satisfactory performance requires an average of 2.75 when the rating performance factors are combined. A random review of five staff performance evaluations verified staff were evaluated yearly and were provided feedback on their job performance. A review of program job descriptions indicated each specified the required qualifications, performance measures, and job duties to include the implementation of the behavioral management system (BMS) and the delivery of specified interventions. A review of the program's contractual requirements indicated all specified key positions were filled and performed, as outlined in the job descriptions.

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

The program has a policy and procedures outlining the provision for recreation and leisure activities which are appropriate for youth at the program. A review of the program's activity schedule reflects youth are given the opportunity to participate in a wide-range of indoor and outdoor recreation and leisure activities. During recreation time, youth participate in the prescribed activity on the recreation calendar or an alternative indoor workout of the day if weather does not permit outside time. In the evenings and on weekends, youth are given a choice of leisure activities. Youth are encouraged to explore interests during recreation and leisure time. Youth are afforded opportunities to provide input into offered activities through the youth advisory board and daily community meetings. The program's recreational therapist position was eliminated effective October 1, 2020 due to the reduction in the budget. Prior to October 1, 2020, the program had a recreational therapist who held a bachelor's-level degree in recreation and sports management with approximatelysix years of experience working with youth. The program maintains a monthly calendar of indoor and outdoor recreation activities planned for the youth targeting and promoting team building and leadership skills. Randomly selected dates and times were reviewed in the program's facility logbooks and confirmed the youth have allotted time each day for recreation. Reviewed documentation of the program's activity schedule, coupled with observations made during the annual compliance review of recreational activities, confirmed youth were provided with at least one hour of outdoor recreation each day. Each of the five interviewed youth stated the program provides at least one hour of recreation and leisure time each day. Five interviewed staff indicated the type of recreation and leisure activities provided to youth are basketball, football, playing cards, arts and crafts, running and exercising, television, and board games for at least one hour.

Standard 2: Assessment and Performance Plan

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

The program has a written policy and procedures to notify each youth's parent/guardian by telephone and in writing regarding each youth's admission into the program. The program's policy identifies procedures regarding the provision of written notification to the youth's committing court for all youth admissions. Five youth case management records were reviewed, and each contained documentation indicating the youth's parent/guardian was notified by telephone within forty-eight hours of the youth's admission to the program. All five case management records included documentation reflecting the youth's parent/guardian was notified, in writing, within forty-eight hours of the youth's admission into the program and written notification to the committing judge and juvenile probation officer (JPO) within five working days of the youth's admission into the program.

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

The program maintains a written policy and procedures to address youth orientation. Five youth case management records were reviewed, and each record contained documentation reflecting the program provided an orientation to the youth within twenty-four hours of admission regarding services available, the daily schedule, expectations, and responsibilities, behavioral management system (BMS), access to medical and mental health services, and access to the Florida Abuse Hotline and/or the Department's Central Communications Center (CCC), for youth over eighteen years of age. The youth's orientation included all of required elements. Each youth was provided a copy of the program's handbook. Each youth record had documentation acknowledging youth received an orientation on the day of admission, as well as a copy of the youth handbook. Observations of one youth orientation during the annual compliance review verified the orientation process was followed according to the program's policy. Five interviewed youth confirmed receiving an orientation to the program within twenty-four hours of their admission.

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

The program's practice is to obtain written consent from any youth who is eighteen years of age or older before providing or discussing with the parent/guardian, or any interested party, information related to the youth's physical or mental health screenings, assessments, or treatments. One of the five reviewed case management records were applicable for youth aged

eighteen or older; therefore, two additional applicable records were reviewed. All three applicable records contained a consent form signed by the youth to allow the program to share, or prevent sharing, information related to the youth's physical or mental health screenings, assessments, or treatments with the parent/guardian.

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

The program has a written policy and procedures regarding the classification screening process. Each youth, upon admission, shall be classified to determine the most appropriate placement. The program's policy ensures the classification of youth is based on the premise youth are assigned rooms and groups to prevent threat or harm of violence to themselves or others and to maximize therapeutic gain. A review of five youth records found documentation indicating each record contained an admission classification form which identified the youth's physical characteristics, age, maturity level, identified special needs, history of violence, gang affiliation, criminal behavior, sexual aggression or vulnerability to victimization, perception of vulnerability, and history of potential or verified human trafficking. A review of the Department's Juvenile Justice Information System (JJIS) confirmed a new Victimization and Sexually Aggressive Behavior (VSAB) was completed and entered prior to each youth's room assignment. The classification form identifies risk factors such as suicide risk, medical risk, escape risk, and security risk. Further review of each youth case record determined each youth was classified for the purpose of assignment to a living area, sleeping room, and group. The program maintains a continually updated internal alert system in JJIS documenting any medical, mental health, substance abuse, security risk factors, and/or special needs identified during or subsequent to the classification process. All five interviewed staff reported all program alerts are maintained and updated, as needed, on an alert board which is accessible to all staff.

The program's policy and procedures address reassessment and reclassification of youth prior to an increase of a youth's privileges or freedom of movement, participation on work projects or other activities which involve the use of tools, or a youth's participation in any off-campus activities; however, due to the COVID-19 pandemic and guidelines from the Centers for Disease Control and Prevention, there was no participation in off-campus activities. The policy addresses reassessments are warranted based upon changes in the youth's supervision status, updated alerts, and relevant information available to the treatment team and/or behavior concerns. The program's practice is to complete a reassessment for every youth each month. All five reviewed youth records contained documentation confirmed reassessment results were discussed during treatment team meetings. An interview with the facility administrator (FA) explained, during the admission process, a classification meeting is held with, at a minimum, the clinical director, case manager, and, by telephone, the parent, guardian, or family member. The program's classification form is designed to gather the information mentioned above, in addition to possible gang membership and whether the youth tends to be a bully. The information is

shared with administration, and a decision regarding unit and room placements are made. On some occasions, during a youth's stay, room assignments may need to be changed due to interpersonal conflicts with peers.

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

The program has a written policy and procedures to screen youth during the admission and classification process to determine if the youth have any gang affiliations. One of the five reviewed case management records was applicable for youth with gang affiliations; therefore, the program provided the only other applicable record from the annual compliance review period for review. The program has identified the case managers as the gang liaisons. Reviewed documentation in each applicable record supported law enforcement was notified, in writing, of each youth's presence in the county and of each youth's gang affiliation. Youth who are identified as a gang member or gang associate have an alert placed in the Department's Juvenile Justice Information System (JJIS) and document supported each of the two applicable youth had alerts entered into JJIS, as well as the program's internal alert system. The gang information was shared with the educational staff at the program, the youth's juvenile probation officer (JPO), and the post-residential services counselor, if applicable.

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

The program has a written policy and procedures outlining the program's process for gang prevention and intervention activities provided to youth. Youth are screened during the admission process to determine if the youth have any gang affiliations. One of the five reviewed case management records was applicable for youth with gang affiliations; therefore, the program provided the only other applicable record from the annual compliance review period for review. The program utilizes the Phoenix Gang curriculum and Impact of Crime (IOC) intervention groups as part of the gang prevention and intervention curriculum. Each applicable youth's performance plan had a gang goal indicating the youth would participate in the monthly gang groups. A review of group sign-in sheets and assignments supported each youth's participation. The program maintains a policy and procedures which addresses gang prevention and intervention activities and procedures to ensure the youth have the opportunity, if they desire, to disaffiliate from a street gang.

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

The program has a written policy and procedures to ensure a Residential Assessment for Youth (RAY) is completed for each youth within thirty days of admission. A review of five youth records indicated each record contained a RAY which was completed within thirty days of admission. Each initial RAY assessment was maintained in the Department's Juvenile Justice Information System (JJIS). Four records were applicable for RAY ninety-day reassessments. All four applicable records documented RAY reassessments were completed, as required. All RAY assessments were maintained in the youth's official case records.

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

The program has a written policy and procedures regarding the completion of a Youth Needs Assessment Summary (YNAS) within thirty days of each youth's admission. Five youth case records were reviewed, and each contained a completed YNAS 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.*	

The program has a written policy and procedures addressing the development of the intervention and treatment plan. The treatment team members, including the youth, meet to develop an Individualized Performance Plan (IPP) based on the findings of the initial assessment of each youth within thirty days of the youth's admission. A review of five youth case management records revealed all IPPs were completed after the completion of the initial assessment and within thirty days of admission, as required. Each youth record documented the plans were developed with the treatment team, which included the intervention and treatment

leader, youth, parent/guardian, administrative representative, living unit representative, treatment staff, education staff by telephone, and all parties who had significant responsibilities in goal completion. Each reviewed plan included the youth's individualized goals, top three criminogenic needs, specific delinquency interventions with measurable goals, based upon the prioritized needs reflecting the risk and protective factors identified during the initial assessment process, to include delinquency interventions, targeted court-ordered sanctions, and identified transition activities. Copies of all five IPPs were sent to each youth's committing court judge, juvenile probation officer (JPO), and parent/guardian within ten days of completion. All five interviewed youth understood the program's treatment process including the development of performance plans and goals on their plans. Each youth reported receiving a copy of their plan.

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

The program has a written policy and procedures in place regarding revisions to a youth's performance plan. The program's treatment team may revise a youth's performance plan at any time a new need is discovered based upon the Residential Assessment for Youth (RAY) reassessment results, or when a youth has demonstrated progress or lack of progress towards completing a goal, and/or when newly acquired information is discovered. Five youth case management records were reviewed and four were applicable for performance plan revisions. Each record reflected revisions were completed due to RAY reassessment results, newly acquired/revealed information, and progress towards completion of the youth's performance plan goals. Three youth were applicable for and received plan revisions in order to facilitate transition activities during the youth's last sixty-days in the program.

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

The program has a written policy and procedures in place regarding the completion and transmittal of performance summaries for each youth at ninety-day intervals, beginning ninety-days from the signing of the performance plan, or at shorter intervals when requested by the courts. A review of five youth case management records revealed four were applicable for ninety-day performance summaries. Each applicable record contained a performance summary completed ninety calendar days following signing of the performance plan. The performance summaries were completed prior to the youth's release, discharge, or transfer from the program. Each summary contained information regarding the youth's status for each performance plan goal, overall treatment progress, academic status and/or credits, behavior, level of motivation/readiness to change, interaction with peers, interaction with staff, overall behavior adjustment to the program, and significant positive and negative events. Each applicable record contained documentation confirming the youth read and added comments to the performance

summaries. Documentation supported each youth received a copy of their performance summary and the original summary was filed in the youth's case management record. Each performance summary was signed and dated by the treatment team leader, staff member preparing the summary, facility administrator, and the youth. Each reviewed record contained documentation to support each performance summary was sent to the youth's committing court, juvenile probation officer (JPO), youth, and parent/guardian within ten days of completion.

Two applicable active youth case management records and onelosed youth case management record were reviewed for discharge and release summaries. Each record contained the original release summary which included the justification for the youth's release from the program. All records contained a Pre-Release Notification (PRN) which was completed forty-five days prior to the youth's release and all summaries and PRNs were signed by the appropriate parties and maintained in the youth closed case management record. Each of the records documented notification to the youth's parent/guardian confirming the youth's release date once the program received the approved PRN from the committing court. Documentation supported each record contained a completed Exit Residential Assessment for Youth (RAY) assessment. There were no youth applicable for the Sexually Violent Predator Program (SVPP) and the victim notification was waived. All three closed records documented the youth's JPOs were provided copies of the performance summaries and transition plans upon completion. Five interviewed youth indicated they each received a copy of their performance summary.

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

The program has a written policy and procedures to provide parental involvement in case management services. The program makes efforts to include the parents/guardians in the assessment process, participation in the development of the youth performance plan, progress reviews, formal treatment team meetings, and transition planning. Five youth case management records were reviewed, and each contained documentation supporting the parents/guardians were mailed an admission letter which included a calendar of all treatment team meetings. If parent/guardians are unable to attend the meetings in person, they are afforded the opportunity to participate by telephone or conference call, or are able to provide verbal or written input prior to the meeting. Attached to the admission letter is a copy of the program's parent handbook which details who will be working with their child, how the program works, treatment and performance team members, medical care, ways of communicating with their child, visitation, program level system, privileges, consequences for negative behaviors, transition planning, assessments, and the grievance process. A review of five youth case management records confirmed each youth had regular telephone contact with their parent/guardian. Each record contained documentation indicating the youth's parent/guardian was invited to participate in the youth's performance planning and treatment meetings. An interview with the facility administrator (FA) indicated parental involvement is encouraged, by inviting parent/guardians to treatment team meetings, visitations, family day, and family sessions. Five youth were interviewed and stated their parent/guardian are 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 has a written policy and procedures identifying treatment team members. The treatment team members consist of the youth, parent/guardian, juvenile probation officer (JPO), direct-care youth counselor, the registered nurse (RN) or representative from the medical department, the clinical director, a member from administration, and a Department of Children and Families (DCF) case worker, when applicable. A review of five youth case management records reflected each representative participated in the case management process to ensure coordinated services were provided to each youth in the program. Reviewed documentation confirmed each youth's JPO was notified and participated in the treatment team meeting by telephone. Observations of treatment team during the annual compliance review verified all members of the treatment team participated in the case management process. The annual compliance review team witnessed the team leader providing the youth feedback regarding transition planning and staff offered praise to the youth for excellent behavior.

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

The program has a written policy and procedures regarding the referencing and/or incorporating of other treatment plans into the youth's Individualized Performance Plans (IPP). Five reviewed youth case management records validated each youth's IPP incorporated the youth's education plans, career education plans, and multidisciplinary intervention to coincide with mental health and substance abuse treatment plans through the treatment team process. The goals included the responsibilities of the program staff in assisting the youth to successfully complete the goal(s). There were no youth involved with The Department for Children and Families (DCF), nor the Agency for Persons with Disabilities (APD).

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

The program has a written policy and procedures addressing formal and informal treatment team meetings. Five case management records were reviewed, and documentation supported formal treatment team reviews were conducted at least once every thirty days. Each record contained documentation supporting informal treatment team meetings were held biweekly to review the youth's performance, progress on Individual Performance Plan goals, behavior, and individual treatment plan, as well as to review Residential Assessment for Youth (RAY) re-assessment results. The program utilized a Performance Plan Review form for informal and formal treatment team meetings which included the youth's name, date of review, comments from treatment team members, brief synopsis of youth progress, positive or negative behaviors, and any RAY revisions. Reviewed documentation confirmed treatment team meeting attendees included the youth, case management staff who acted as the treatment team leader, clinical

staff, education, and a program administration representative. Each youth's juvenile probation officer, parent(s)/guardian(s), and other pertinent parties were invited to participate in person, by telephone, and/or provide written input. During informal treatment team meetings, the treatment team members reviewed the progress of each youth's goals, behaviors, physical interventions, treatment progress, and RAY reassessment results. All staff gave relevant input on the youth and agreed on how to proceed to formal treatment team. Five interviewed youth stated, during treatment team reviews, staff review their performance to include progress on performance goals, positive and negative behaviors, and treatment progress. Observations of a formal treatment team meeting during the annual compliance review confirmed this practice.

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

The education program has a written policy and procedures addressing the career education curriculum. Career education is provided by the School District of Broward County and is identified as a Type 2 Career Educational program. The course programming includes instruction of interpersonal communication skills, personal accountability skills, and behaviors leading to appropriate work habits for positive post-release employment and living standards. This curriculum, which is age appropriate for youth in the program, is suitable to each youth's learning and ability skills. The programming provides an orientation to the broad scope of career choices based upon personal abilities, aptitudes, and interests. The program provides the Naviance Program, which is an individualized compentecy program which assesses and assists youth to deveop competencies and skills for post-secondary academic success in either employment or continued education. The program provides culinary arts, and Serv-Safe certifications, as well as The Forklift Operator initiative, which affords the youth training and experience in operating a forklift by a forklift simulator. Three closed youth case management records were reviewed and supported each youth participated in career education. Each record contained a résumé, sample employment applications,, and a post-release calendar (Plan for Success) which identified the location of and contact information of a Career Source office either in or near the community in which the youth will reside upon exit from the program, as well as appropriate documentation to gain employment including a valid state-issued dentification card, a birth certificate, and social security card. Additionally, each record contained documentation supporting the youth's parent/guardian, juvenile probation officer, as well as the youth's program case manager were aware of the youth's vocational plans and post-release discharge plans. An interview with the facility administrator and the lead teacher indicated each youth attends vocational and employment exploration classes during the school day.

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

The program's educational component is directly managed and supervised by the Broward County School District. Reviewed documentation, as well as an interview with the program's lead instructor, indicated each youth in the program was provided a minimum of 250 days instruction during the calendar year and each calendar week contained a minimum of twenty-five hours of classroom teaching. To provide teacher preparation/planning, ten planning days were incorporated into the calendar year. A review of the program's daily academic schedule

indicated the school day started at 7:30 a.m. and concluded at 12:45 p.m. A review of the program's logbooks and interviews with five youth supported educational instruction was provided with minimal interruption. Due to the COVID-19 pandemic and in accordance with the Centers for Disease Control and Prevention guidelines, classes were conducted virtually with the aid of Google Classrooms and supplemental educational packets were incorporated into the curriculum delivery. Since October 15, 2020, the program has been on a hybrid instructional model. The program has three teachers teaching remotely and three teachers on-site. Prior to the administration of the hybrid model, educational classes were delivered 100% remotely. This model began on March 13, 2020 and was terminated with the introduction of the hybrid model. The current hybrid model will expire on January 11, 2021, at which point (should this date remain firm), the teachers will report for 100% face-to-face instruction.

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

The purpose of the Educational Transition Plan is to formulate and provide to the youth, services and interventions which are based on the youth's assessed educational needs and post-release education plans, and is created within the first ten days of the youth's entry into the program. Three closed youth case management records were reviewed, and each record documented the individual transition plans were initiated during the youth's admission process and contained all required elements. Each reviewed record contained documentation indicating the youth was involved in the development of the transition plan. The plan addressed different services and interventions based on the youth's assessed educational needs and post-release education plans. Documentation supported services were provided during the youth's stay in the program and services were implemented upon release. The education transition educational plans included recommended educational placements post-release, as well as specific monitoring responsibilities by individuals who are responsible for the reintegration and coordination of the provision of support services. Each of the plans documented participation by all required parties.

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

The program has a written policy and procedures addressing transition planning conferences and Community Re-Entry Team (CRT) meetings. Three closed youth case management

records were reviewed each reflected each youth had a transition conference conducted at least sixty days prior to the youth's targeted release date. All required participants were invited to participate in person, by telephone, or provide verbal or written input prior to the meeting if unable to attend. Copies of the plans were sent for return signature to individuals not in attendance. Documentation from each of the transition conferences confirmed the team reviewed the youth's transition activities, revised the performance plan, identified additional transition activities, target dates for completion, and persons responsible for completion. All required signatures were obtained. Each record had documentation indicating a copy of the transition plan was electronically sent to the juvenile probation officer (JPO). All three records contained an electronically signed copy of the plan. In each of the three closed records, documentation confirmed the youth and case manager were invited and participated in a Community Re-Entry Team (CRT) meeting prior to the youth's release from the program.

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

The program has a written policy and procedures outlining the process for the transition of the youth back into the community, to include exit portfolios. The program develops an exit portfolio for each youth during the transitional phase of the program. Two of the five reviewed youth records were applicable for an exit portfolio; therefore, one additional applicable record was reviewed. Each of the case management records indicated an exit portfolio was discussed and initiated during or prior to the youth's transition meeting. The program's practice is to transport the youth to the Division of Motor Vehicles (DMV) to obtain a state-issued identification card. Due to the COVID-19 pandemic and in accordance with the Centers for Disease Control and Prevention guidelines, the DMV office was closed; therefore, two of the three youth did not obtain a state-issued identification card. Reviewed documentation reflected follow-up appointments were made in each youth's home county upon release. Reviewed documentation confirmed all three youth received a copy of the transition plan, as well as a calendar with dates, times, and locations of follow-up appointments in the youth's home community. All three exit portfolios contained a copy of the youth's birth certificate, social security card, education and vocation certificates each youth earned in the program, school transcripts, resume, and a completed sample employment application. In addition, signed documentation indicated each youth was given a copy of the exit portfolio upon release from the program.

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

The program has a written policy and procedures in place regarding exit conferences. Three reviewed closed case management records found each record contained documentation indicating an exit conference was conducted at least fourteen days prior to the youth's release, as required. Reviewed documentation in all three exit conferences supported the treatment team leader, educational staff, youth, the assigned juvenile probation officer (JPO) participated by telephone or documented attempted telephone contact with the parent/guardian, case manager, the facility administrator or designee, mental health staff, and medical staff participated in person. Each reviewed exit conference was documented in the youth's records and included the date, summary of pending goals, and signature of participants. A review of the

Department’s Juvenile Justice Information System (JJIS) reflected the date of the youth’s admission and release date from the program was accurate

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

The program has a written policy and procedures addressing the safety planning process for youth. The program maintains safety plans for each youth which are maintained in master control and accessible to all staff. Five youth mental health and substance abuse records were reviewed, and each record contained a safety plans developed within the fourteen days of arrival to the program. The reviewed records indicated each safety plan was jointly prepared by the youth, parent/guardian, case manager, and clinical staff and contained all required elements. Reviewed documentation confirmed youth contributed to the safety plans which were updated at least once every thirty-days. Documentation supported recommendations from the previous or current clinical assessment or screening instrument were incorporated. Reviewed documentation indicated each of the reviewed safety plans were updated every thirty-days or following any significant behavioral or mental health event identified by the youth’s intervention and treatment team. Five interviewed staff stated the safety plans are reviewed daily and whenever youth are having a bad day. Each staff knew the location of the safety plans.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a designated mental health clinician authority (DMHCA) who is a licensed mental health counselor (LMHC), and licensed marriage and family therapist (LMFT). The DMHCA holds a Doctor of Philosophy (Ph. D). A review of the DMHCA's licenses showed they are clear and active in the State of Florida, both with an expiration date of March 31, 2021. The DMHCA reported being on-site at least forty hours a week, Monday through Friday, and is on-call twenty-four hours a day, seven days a week for consultation and emergencies. The DMHCA is responsible for the coordination and implementation of mental health and substance abuse services in the program. The program's DMHCA ensures compliance with the requirements of the Substance Abuse Treatment Overlay Services (SAOS) and the other mental health and substance abuse services provided by the program. In addition, the DMHCA ensures proper completion of documentation and integration of the program's mental health and substance abuse system with the State of Florida and the federal guidelines. The DMHCA participates in the overall programming and administration of youth treatment, and emergency consultation services, weekly face-to-face clinical supervision for the three non-licensed clinicians, management meetings attendance, provision of training and support services, as needed, within the program. Additionally, the DMHCA is responsible for reviewing and signing all comprehensive mental health evaluations, Assessments of Suicide Risk (ASRs), initial treatment plans, individualized treatment plans, and monthly treatment plan reviews completed by the non-licensed clinicians. Interviews with the facility administrator (FA) and the DMHCA confirmed the program offers the SAOS to all youth.

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.	

In addition to the designated mental health clinician authority (DMHCA), the program maintains an agreement for professional services with a State of Florida American Board of Psychiatry and Neurology certified licensed psychiatrist. The psychiatrist is scheduled to be on-site four hours a week. A review of sign-in logs for the last six months and an interview with the psychiatrist validated this practice. Reviewed documentation found each licensed clinician maintained a clear and active license in the State of Florida. The reviewed records demonstrated each staff worked within the scope of their licensure, experience, and training. The program is licensed through the Department of Children and Families (DCF) in accordance

with Chapter 397, Florida Statutes, to provide substance abuse services for outpatient treatment. A review of the program's Chapter 397 license showed it was active until April 1, 2021. An interview with the DMHCA verified they and the psychiatrist are on-call for emergencies and consultation twenty-four hours a day, seven days a week.

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

The program has three master's-level, full-time, non-licensed therapists providing services to youth at the program. A review of clinical supervision logs reflected the three non-licensed therapists completed weekly on-site face-to-face clinical supervision lead by the licensed designated mental health clinician authority (DMHCA), since the last annual compliance review. The reviewed clinical supervision logs included a review of case notes, history, caseload directions, review of fidelity checks, clinical service instructions, documented strengths, findings, trends, and/or problem areas, situational concerns, and training. Each reviewed direct supervision log was documented on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form. A review of each therapist's caseload assignment revealed each therapist had a caseload within the contractual limit of sixteen youth. A review of the training records for the three non-licensed staff validated completion on the Department's Non-Licensed Mental Health Clinical Staff Person's Training in Assessments of Suicide Risk form, of the required twenty-hours and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. Training documentation included the administration of five Assessments of Suicide Risk or crisis assessments conducted on-site in the physical presence of a licensed mental health professional. The program is licensed through the Department of Children and Families (DCF) in accordance with Chapter 397, Florida Statutes, to provide substance abuse services for outpatient treatment.

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 policy establishes the method in which mental health and substance abuse services are provided to all youth. The policy outlines the pre-screening process by which a youth's individualized history is reviewed and an admission screening is completed. A review of five individualized mental health and substance abuse youth records showed the program administered a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) screening to each youth on the day of admission. The MAYSI-2 screenings were completed in the Department's Juvenile Justice Information System (JJIS) by a trained staff. Each reviewed record documented the review of available information to include the commitment packet, reports, and records of existing documentation of mental health or substance abuse problems. Each of the five reviewed records contained screenings administered by a trained mental health staff working under the direct supervision of the licensed designated mental health clinician authority (DMHCA). Interviews completed with the facility administrator (FA) and the director of

case management indicated the youth are immediately administered a MAYSI-2 within one hour of admission to the program. This screening includes any risks the youth might have for suicide and drug use. If the screening indicates an elevated risk of suicide, the youth is immediately placed on a suicide alert and an Assessment of Suicide Risk (ASR) is completed to determine the need to remain on suicide alert and/or suicide precautions. The DMHCA indicated findings from the MAYSI-2 screening determine which additional screenings are administered to the youth. The results of the initial and/or subsequent screenings, thorough review of records provided by interviews with and behavioral observations of the youth, and one or more interviews with the parent/guardian and assigned juvenile probation officer (JPO) are compiled by the mental health therapist to develop the comprehensive assessment.

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 written policy and procedures outlining the process by which all youth are referred to a licensed mental health service provider for the completion of a mental health and substance abuse evaluation. The program's practice is to complete a new compressive bio-psychosocial mental health and substance abuse evaluation instead of up-date prior assessments, based on the identified needs, for each new admission. A review of five individualized mental health and substance abuse records showed each youth was referred for an evaluation the day of admission and each evaluation was completed within thirty days of admission, as required. All five reviewed comprehensive evaluations were completed by a master's-level therapist working under the direct supervision of the designated mental health clinician authority (DMHCA). Each comprehensive evaluation was signed within ten calendar days by a licensed staff, as required. Each reviewed new evaluation documented the youth's identifying information, reason for evaluation, relevant background information, behavioral observations, mental status examinations, procedures administered, discussion of findings, diagnostic impressions, and recommendations. Each reviewed record was applicable for a substance abuse diagnosis and contained a substance abuse assessment. Each record documented a consent for substance abuse services and urinalysis. All substance abuse evaluations were completed within thirty days, as required. Each reviewed substance abuse assessment included the reason for assessment, behavioral observations, methods of assessment, patterns of alcohol and drug abuse, impact of alcohol and drug abuse on major life areas, risk factors of continued alcohol and other drug abuse, clinical impressions, recommendations, and the original referral reason. An interview with the program's DMHCA revealed during the first two weeks of a youth's admission, the primary therapist completes a Beck Depression Inventory, a Substance Abuse Subtle Screening Inventory (SASSI), a Suicide Probability Scale (SPS), a Comprehensive Bio-Psychosocial Mental Health and Substance Abuse Evaluation, and a screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) assessment. Training documentation reviewed confirmed program staff received training in mental health and substance abuse issues and administration of the Massachusetts Youth Screening Inventory – Second Version (MAYSI-2). The DMHCA further explained the initial assessments, and the follow-up assessments are included within the comprehensive mental health and substance abuse assessment in addition to all pertinent information from the initial screening, parent/guardian interviews, the youth's assigned juvenile probation officer interviews, and youth behaviors exhibited during the first few weeks at the program are included in the evaluations completed.

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 written policy and procedures regarding the mental health and substance abuse treatment. The policy requires the program to provide individualized, trauma-informed, and developmentally appropriate mental health and substance abuse treatment to all youth in the program who are determined to meet clinical criteria. Additionally, mental health and substance abuse treatment is provided on-site through the provision of Substance Abuse Treatment Overlay Services (SAOS). An interview with the DMHCA revealed they monitor all the non-licensed therapists who provide substance abuse groups. All program therapists received face-to-face training to provide substance abuse education, and the program conducted regular fidelity checks. The program's SAOS include substance abuse treatment, evaluations, individualized substance abuse treatment planning, daily services, individual, group, and family substance abuse counseling, crisis intervention therapy and management, mental health evaluation and treatment for youth with co-occurring mental disorders, twenty-four-hour response capability with access to acute care settings and mental health emergency management services, routine and random urinalysis drug testing with positive tests followed by appropriate clinical intervention and sanctions, capability to provide psychopharmacological therapy, psychiatric and psychological consultation and services, and psychiatric services, as needed.

A review of five individualized mental health and substance abuse records documented each youth was assigned to a treatment team on the day of admission. Each multidisciplinary team was comprised of all required members. Each of the records contained an active Authority for Evaluation and Treatment (AET) form, as well as a substance abuse treatment consent. The program is licensed under Florida Statute, Chapter 397, and certified through the Florida Department of Children and Families (DCF), to provide substance abuse services for adolescents. Each of the reviewed mental health and substance abuse treatment records contained weekly progress notes which included all elements of the Department's Counseling/Therapy Progress Note form. Each reviewed progress note form included the youth's identifying information, date of services, start and end time of services, type of service, number of participants, curriculum, clinical interventions, youth response, summary of overall progress in treatment for the week, goals addressed during the week, summary of significant events, summary of family involvement, and the primary therapist's and designated mental health clinician authority (DMHCA) signatures. Behavioral observations, medication responses, and progress in treatment are discussed with the psychiatrist and are conveyed during monthly formal treatment team meetings. All goals and objectives on the treatment plan are reviewed and documented during the formal monthly meeting and the required reviews are timely made to the treatment plans. The frequency of prescribed services for each youth's individual, group, and family services are daily, and all the services were provided, as prescribed. A review of group sign-in sheets confirmed group therapy is limited no more than ten youth for mental health groups and fifteen youth for substance abuse groups. Interviews completed with five youth confirmed their participation in family and individual counseling at least twice a month.

Interviews completed with five staff revealed direct-care staff facilitate mental health or substance abuse groups to demonstrate to youth social skills.

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 written policy and procedures regarding treatment and discharge planning. The program has a comprehensive plan for mental health and substance abuse services in place. The plan outlines responsibilities and required elements of mental health and substance abuse treatment services and discharge planning. The plan states treatment planning at the program includes an initial mental health and substance abuse treatment plan and individualized mental health and substance abuse treatment plans, monthly treatment plan reviews, and discharge planning. A review of five individualized mental health and substance abuse youth records showed an initial treatment plan was developed for each youth on the day of admission. Each was documented on the program's form and contained all elements outlined in the Department's Initial Mental Health/Substance Abuse Treatment Plan form. All the five plans were completed by a master's-level mental health staff working under the direct supervision of the licensed DMHCA. The DMHCA signed the five initial plans within ten calendar days, as required. All five initial plans contained signatures of all treatment team members participating in the development of the plan. Each of the five reviewed initial treatment plans documented the youth's psychiatric needs to include prescribed medication and medication monitoring frequency.

A review of five youth mental health and substance abuse records found each record contained an individualized treatment plan documented on the program's form containing all elements in the Department's Individualized Mental Health/Substance Abuse Treatment Plan form. The program's individualized treatment plan form included the youth's identification information, Diagnostics and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, symptoms supporting diagnostic criteria, any changes in diagnosis, youth and family strengths, needs, and ability preferences, services to be provided, clinical goals, youth interpretations of clinical goals, objectives, status and date, target completion dates, progress summary, summary of additional services, youth overall progress in program, medication details, and signatures of treatment team members. Each reviewed individualized plan was developed within thirty days of admission and signed by the non-licensed clinical staff person creating the plan, working under the direct supervision of the DMHCA, and all treatment team members who participated in plan development. Each of the plans were signed by a licensed staff within ten days, as required.

Each reviewed record contained treatment plan reviews which were completed every thirty days, as required. The reviews documented the youth's identifying information, DSM-5 diagnosis, symptoms supporting diagnostic criteria, any changes in diagnosis, clinical goals, youth interpretations of clinical goals, objectives, status and date, target completion dates,

progress summary, summary of additional services, youth overall progress in program, medication details, and services to be provided. Each treatment plan review was documented on the Department's Individualized Mental Health and Substance Abuse Treatment Plan Review form.

Five additional closed youth individualized mental health and substance abuse records were reviewed for the completion of mental health and substance abuse discharge plans. Each of the records contained a discharge plan documented on the Department's form and included all elements required. Each of the discharge plans were completed by the individualized treatment team on the same day of each youth's exit staffing. None of the records were applicable for notification of suicide risk upon discharge. Each youth's discharge summary listed the services needed for daily maintenance of the positive improvements in behavioral, emotional, and social skills made by the youth during treatment. Each discharge summary documented the youth's progress in treatment while participating in the program, relevant health and substance abuse history, the reason for recommending on-going treatment, and youth and parent/guardian participation. Reviewed documentation confirmed the discharge summaries were discussed with the youth, parent/guardian, and assigned juvenile probation officer (JPO) during the exit conference, and the program sent the mental health and substance abuse discharge plans to the youth's parent/guardian for signature, and the JPO by mail upon release. An interview with the DMHCA reported within thirty days of the development of the individualized treatment plan, each youth receives a treatment plan review during which the youth's goals and objectives are reviewed and updated. The DMHCA revealed the program's mental health therapists utilize the comprehensive assessment as a guide in developing the youth's individualized treatment plan.

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

The program has written policy and procedures regarding specialized treatment services. A review of the program's contract and clinical program description found the program provides Substance Abuse Treatment Overlay Services (SAOS) to all youth in accordance with Florida Statute and Administrative Rule. In addition, the program maintains a written comprehensive plan for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The plan outlines specific SAOS provided at the program to include individual, family, psychoeducational, supportive, and group counseling. The program provides evidence-based or promising treatment practices with a basis on restorative justice philosophies, principles, and practices. The program's contract, written plan for mental health and substance abuse services, and youth activity schedule reflect youth are provided group therapy services. Youth are provided group therapy services to include Skillstreaming the Adolescent, Living in Balance, Seeking Safety, Mindfulness for Addictions, Stop the Chaos, Talks my Father Never had with Me, Men's Trauma and Empowerment Model (M-TREM). A review of the applicable sign-in sheets confirmed the groups were held as require. Thinking for a Change, and Impact of Crime. A review of five youth records confirmed participation in groups. The program maintains separate and individual binders for each group and curriculum which contains youth sign-in sheets. The program's Youth/Parent Program Handbook contained a treatment contract form for each youth, to ensure confidentiality for all treatment groups information. A review of video footage for six complete groups confirmed the delivery of groups practice on different dates, times, and types of groups. Each group observed was for at least fifty minutes.

The program maintains a written policies and procedures for substance abuse services to establish a method in which substance abuse treatment services shall be provided to youth. The program is licensed through the Department of Children and Families (DCF) in accordance with Chapter 397, Florida Statutes, to provide substance abuse services for outpatient treatment. Each of the five reviewed youth record contained weekly progress notes which supported groups were provided to youth, as scheduled. Interviews with the designated mental health clinician authority (DMHCA) revealed all mental health staff are assigned groups, along with a list of youth names they are responsible for providing groups to. The therapists are responsible to ensure groups are provided all youth assigned to them. The DMHCA indicated attendance for group therapy sessions is verified by sign-in sheets. The program did not have a trained therapist in (M-TREM) to deliver the service; however, the program has a licensed mental health professional who can facilitate curriculum without a formal training based on the developer's model. However, the program did not have any youth with severe trauma identified to participate in M-TREM groups during the annual compliance review period. The program met all requirements for SAOS specialized treatment services during the annual compliance review period due to being in compliance with all substance abuse groups, which were delivered as designed.

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

The program maintains an independent psychiatrist agreement with a board-certified licensed psychiatrist for the provision of weekly on-site, part time psychiatric screenings, assessments, evaluations upon a youth's admission, as well as psychiatric consultation and psychopharmacological therapy to youth receiving psychotropic medications. Medical and psychiatric follow-up visits are to be conducted on an individualized basis. A review of the psychiatrist's license showed it was clear and active in the State of Florida with an expiration date of January 31, 2022. The psychiatrist is a licensed medical doctor with a specialty in child and adolescent psychiatry. A review of psychiatrist sign-in sheets since the last annual compliance review supported the psychiatrist was on-site weekly, as required. Documentation reviewed and an interview with the health services administrator (HSA), who is also a registered nurse, revealed when the psychiatrist is absent or on vacation, youth are sent to the hospital office of the same psychiatric doctor. The program does not utilize an advanced registered nurse practitioner (ARNP).

A review of five individualized mental health and substance abuse records showed each record contained a psychiatric initial diagnostic interview completed within fourteen days of the youth's admission to the program. Each diagnostic interview documented the youth's history, Mental Status Examination, Diagnostics and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, applicable prescribed medications, and frequency of medication monitoring, if applicable. All five reviewed records documented the initial diagnostic psychiatric interview, and any parent/guardian's verbal consent for psychotropic medications on the Department's Clinical Psychotropic Progress Note (CPPN) form, and each contained page three of the CPPN completed within the required time frame, as outlined in policy. Two of the five reviewed youth

records were applicable for youth taking psychotropic medications. Each applicable record documented the youth received medication reviews at least every thirty days, as required. Reviewed documentation supported there were no standing or emergency treatment orders for psychotropic medications for psychotropic medications. Both applicable records documented contained all required information regarding psychotropic medication including the youth's identifying information, diagnosis, target symptoms of each medication, prescribed medications, side effects, and the youth's adherence to the medication regime. Each record documented telephone contact with the youth's parent/guardian, the psychiatrist's dated signature, and monthly Tardive Dyskinesia monitoring. An interview with the psychiatrist validated they are on-site two hours a week and provide evaluations and medication management. The psychiatrist indicated they have no concerns with the healthcare provided at the program.

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

The program maintains a written policy and procedures to establish a method in which suicide prevention services shall be provided to all youth. The program maintains a written Suicide Prevention Plan. The program's suicide prevention plan was reviewed and signed by the designated mental health clinician authority (DMHCA) on August 2, 2019. A review of the program's suicide prevention plan showed it included identification, assessment, suicide precautions, and procedures for the use of precautionary observation, serious suicide attempts, or serious self-inflicted injury review and mortality reviews, as well as training. An interview with the program's facility administrator (FA) indicated the program provides suicide prevention training during the mandatory pre-service and in-service trainings. The FA reported the program conducts emergency mental health drills, to include emergency response to suicide attempts or self-inflicted injury, at least quarterly on each shift, as required.

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

The program maintains a written suicide prevention plan and facility operating procedures for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. Suicide prevention is provided at the program through the implementation of the suicide prevention plan. The plan includes suicide precautions, a process for every serious suicide attempt or serious self-inflicted injury, and a mortality review for a completed suicide. None of the reviewed youth records were applicable for suicide prevention services. A review of staff training records reflected all direct care staff and non-direct care staff received ongoing on-site training regarding suicide prevention, crisis

intervention, and emergency care. A review of five youth mental health and substance abuse records validated the program completed one Assessment of Suicide risk (ASR) for each youth upon admission, regardless any concerns or intake results. Each of the five records documented an ASR was completed using the Department's ASR form within twenty-four hours, as required. All the ASRs were reviewed and entered into the Department's Juvenile Justice Information System (JJIS), and alerts were documented by clinical staff, when applicable. There was evidence in the program's logbooks reviewed and, on the ASRs, completed, the administrative and supervisory staff provide instructions related to the ASR findings and suicide precautions decisions. An interview with the program's designated mental health clinician authority (DMHCA) revealed the program does not utilize secure observation (SO). Five interviewed staff indicated if a youth expresses suicide thoughts, staff are responsible to notify mental health staff, search the youth and room, place youth on constant sight and sound supervision, and document supervision. The staff indicated the program has a knife for life, wire cutters, and needle nose pliers in master control and in the sub-controls. Interview completed with the DMHCA indicated for youth referred for an ASR or mental health crisis assessment during business hours, the mental health professional is notified of the referral verbally and by the referral form. After hours, the on-call licensed mental health staff is notified of the referral and any placement on precautionary observation or mental health crisis alert initiated by the therapist or non-mental health therapist. The referral for updates psychiatric evaluation is given to medical staff. If the referral indicates a non-emergency situation, the youth is scheduled to see the psychiatrist at the next visit. If the situation is an emergency and the psychiatrist is not on-site, the psychiatrist is notified by telephone. Both a licensed mental health professional and the psychiatrist can be notified seven days a week, twenty-four hours a day. The director of treatment indicated the staff with the first indication of the youth's potentially suicidal ideation/gesture contact the shift supervisor, who is responsible for supervisory oversight of the process and associated documentation, validation master control is notified validation the facility administrator (FA) and license mental health professional are contacted for concurrence and recommendation, validation the information is posted on the alert board.

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 maintains a written suicide prevention plan in place outlining staff supervision and documentation requirements during precautionary observation (PO), and facility operating procedures for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The plan outlines requirements for youth maintained on PO. None of the five reviewed individualized mental health and substance abuse records were applicable for completion of a precautionary observation log. An interview with the designated mental health clinician authority (DMHCA) confirmed two youth previously the program were applicable for suicide precautions during the annual compliance review period. Both reviewed Suicide Precaution Observation Logs found each was maintained for the duration the youth was on suicide precautions and were documented in real time. Each log documented the identification of safe hoursing areas, and observation of the youth's behavior. Each shift supervisor and mental health staff signed the logs daily, as required.

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

The program maintains written pre-service and in-service training plans, both of which were approved by the Department's Office of Staff Development and Training (SDT). Both plans outlined suicide training requirement for all program staff. Reviewed training documentation confirmed each of the five direct care staff received six hours of pre-service annual suicide training, and five staff also received six hours of in-service annual suicide training, as required. Training was conducted face-to-face by the program's staff, as well as web-based in the Department's Learning Management System (SkillPro). A review of the program's suicide drills found all the completed drills included the use of life saving measures including the use of cardiopulmonary resuscitation (CPR) or an automated external defibrillator (AED). A review of the completed drills against the program staff roster showed each of the reviewed staff participated drills semi-annually. A review of suicide and mental health drills since the last annual compliance review supported drills were conducted quarterly on each shift, as required. Each reviewed drill documented a description of the incident, a synopsis of the response, identified deficiencies, corrective action, and staff involved. An interview with the facility administrator (FA) revealed fire and emergency medical drills are completed once on each shift every month. COOP drills such as bomb threat, hurricane, and hostage situation are held quarterly across campus. Five interviewed staff reported the program conducted medical emergency and suicide drills at least once a quarter.

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 maintains a written policy and procedures to establish procedures for responding to youth in crisis in the least restrictive method possible. This is done to protect the personal safety of the youth, staff, and others while maintaining safety and control of the program. The program's policy establishes a method of crisis intervention services to be provided to all youth. The program maintains a written crisis intervention plan which was reviewed, approved, and signed by the facility administrator (FA) and the designated mental health clinician authority (DMHCA) on October 26, 2020. The reviewed crisis intervention plan included verbal de-escalation and Protective Action Response, notification and alert system, referrals including youth self-referral, crisis assessment and follow-up mental status examination, communication, supervision, mental health supportive services, and documentation and review. The plan includes a list of crisis contact numbers within the program, and one emergency contact telephone number, including Poison Control.

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

None of the five reviewed individualized mental health and substance abuse records were applicable for crisis assessment; however, the program provided the only additional applicable record from the annual compliance review period for review. The review of the applicable record indicated the program completed the crisis assessment at the date and time youth was determined to be in crisis. The assessment included the reason for assessment, a mental health status examination and interview, determination of danger to self and/or others, initial clinical impressions, supervision recommendations, treatment recommendations, parent/guardian notification, and recommendations for follow-up. The assessment was conducted within the required time frame by a non-licensed mental health counselor and reviewed within twenty-four hours by the DMHCA and the facility administrator (FA). Reviewed documentation confirmed the youth was placed on one-on-one supervision and an Mental Health Alert Observation Log was completed while the youth remained on a mental health alert The follow-up mental status examination completed by the non-licensed mental health staff was reviewed and signed by a licensed mental health staff, as required.

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 maintains a written policy and procedures to establish a method in which emergency mental health and substance abuse services will be provided to all youth. The program maintains a written emergency response Plan, reviewed and approved, and signed by the facility administrator (FA) and the designated mental health clinician authority (DMHCA) on August 2, 2019. The reviewed emergency response plan included immediate staff response, notifications, communication, supervision, authorization of transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment, Chapter 394 Florida Statute (Baker Act), transport for emergency substance abuse assessment and treatment/Chapter 397 Florida Statute (Marchman Act), return from emergency mental health or substance abuse services, documentation, training and drills, and review. All staff have the right to immediately contact 9-1-1 and have access to the suicide response kits and rescue tools in case of emergency. The Youth/Parent Program Handbook contained an emergency procedures section. The program utilizes Memorial Regional Hospital located in Hollywood, Florida for the crisis stabilization unit.

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

The program maintains a written emergency response plan addressing Baker and Marchman Act proceedings. A review of five youth mental health and substance abuse records found none of the youth were applicable to Baker Act or Marchman Acts; however, two additional applicable records were reviewed. Each of the applicable records documented the program's clinical staff immediately placed the youth on one-on-one supervision and completed the Mental Status Examination (MSE), Assessment of Suicide Risk (ASR), Certificate of Professional Initiating Involuntary Examination, and Baker Act youth. One of the two youth returned to the program following the Baker Acts and was placed on constant supervision and had Mental Health Status Exams conducted. The youth had an ASR completed by the DMHCA and was maintained on constant supervision until properly transitioned to a lower level of supervision. The program did not utilize a Marchman Act during the annual compliance review period.

Standard 4: Health Services

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

The program maintains a written policy and procedures ensuring a health authority shall be responsible for the healthcare services provided. The program maintains an independent contractor agreement with a State of Florida physician to serve as the designated health authority (DHA) signed on October 24, 2014. The contract automatically renews each year. The DHA holds an active, unrestricted license under Chapter 458, Florida State Statute, with a license expiration date of January 31, 2022 and is a medical doctor with specialty training in pediatrics. The medical doctor holds professional liability insurance with an expiration date of October 24, 2021. The program does not utilize an advance practice registered nurse or physician's assistant. The DHA is scheduled to be on-site for approximately two hours weekly. Reviewed physician logs for the past six months supported the DHA was on-site weekly, as required. In the event the DHA cannot be on-site, duties have been delegated to medical doctor to act on behalf of the DHA. The back-up medical doctor holds an active, unrestricted license under Chapter 458, Florida State Statute which expires on January 31, 2021. The back-up DHA holds professional liability insurance which expires on October 24, 2021. The DHA is responsible for communication with program staff regarding youth medical needs, and is available for consultation twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. The scope of services includes medical screenings, assessments and evaluations, provide medication evaluation and on-going monitoring of medications and chronic medical medications. Supporting documentation reflected the DHA consults and works with the treatment team members in developing and modifying treatment plans and performance plans, as needed. An interview with the DHA confirmed their role includes performing Comprehensive Physical Assessments, sick call, and periodic evaluations, as well as reviews healthcare policies and procedures and nursing protocols.

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

The program maintains facility operating procedures for all health-related procedures and protocols utilized. The program's assigned designated health authority (DHA) conducts an annual review of all health-related policies, procedures, and protocols. Reviewed documentation validated the DHA signed all healthcare policies and procedures on August 5, 2020, and the facility administrator documented a review on October 27, 2020. The program maintains two full-time registered nurses (RN). One RN is the program's health services administrator (HSA). The program maintains a training requirement whereby newly employed healthcare staff shall receive a comprehensive clinical orientation to the Department's healthcare policies and procedures, to include Administrative, provided by the HSA. Reviewed training curricula and plan reflected a new nursing staff would receive the required pre-service and orientation training to include on-the-job training. The program did not hire any new nursing staff since the last annual compliance review. The program maintains a nursing protocol manual developed and approved by the DHA on August 5, 2020. Reviewed nursing staff training records validated training on the treatment protocols and healthcare policies and procedures on September 25, 2020. Treatment protocols were reviewed by the DHA on August 5, 2020 and remained

effective without change. FOPs related to psychiatric services and psychotropic medication management were reviewed and signed by the program's regional clinical director who is a licensed mental health counselor. The FOP was subsequently reviewed and signed by the contracted psychiatrist during the annual compliance week.

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.	

The program maintains a written policy and procedures ensuring parents/guardians are afforded the right to give or withhold consent regarding the healthcare provided to their children. The Authority for Evaluation and Treatment (AET) form is signed by the parent(s) who have legal custody or by the legal guardian and the AET serves as informed consent for non-invasive medical procedures which can be treated by healthcare staff or for minor ailments requiring over-the-counter (OTC) medications. The signed AET is valid until the parent/guardian revokes or modifies it, or the youth leaves the custody of the Department. The program utilizes a separate form for youth eighteen years of age or older providing consent for release of specific information, as noted on the Release of Information Authorization for Youth Eighteen Years of Age and Older form, and to whom the information can be released and shared. A review of five youth healthcare records found each was applicable for a signed AET. Each reviewed youth healthcare record contained a copy of the signed AET and the word, "Copy" was clearly stamped on each. One youth turned eighteen years old post-admission to the program and the youth healthcare record contained the required signed consent. Each reviewed AET and/or Release of Information Authorization for Youth Eighteen Years of Age and Older was filed in the youth's healthcare record in the appropriate section. The program had no youth who were under the supervision of the Department of Children and Families. There were no original AETs reviewed. An interview with nursing staff indicated the registered nurses review all admissions in the Department's Juvenile Justice Information System (JJIS) and validate the AETs. If needed, the assigned juvenile probation officer would be contacted through the case manager to obtain a new AET.

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

The program maintains a written policy and procedures ensuring the parent/guardian is informed of significant changes in the youth's medical and/or mental health condition and to obtain consent when new medications and treatments are prescribed. Procedures ensure the parent/guardian is notified to obtain consent of new psychotropic medications, discontinuances, or psychotropic medication adjustments. Five reviewed healthcare records supported three were applicable for parental notifications. Reviewed documentation supported each parent/guardian was notified when significant changes to existing medication occurred or when changes in condition and/or medication for youth identified with a chronic condition. Two of the three reviewed youth records required parental notification for over-the-counter (OTC) medication beyond those covered by the Authority for Evaluation and Treatment (AET) and documentation supported parental notification was sent. One reviewed youth healthcare record was applicable for off-site emergency care and reviewed documentation supported the parent/guardian was notified. Verbal parental/guardian consent is obtained as soon as possible after an order is written. Verbal consent is obtained for any OTC medication which has not been

previously approved. For new prescriptions, significant dosage changes, or for discontinuing a medication, a parental notification is completed. All attempts are made to verbally contact the parent/guardian prior to a youth leaving for the emergency room (ER). The parent/guardian is contacted upon the youth's return with the results of the ER visit. Written notification is completed after the return from the ER. Nursing interviews indicated parental/guardian notifications are written and sent the same day as the event to include off-site appointments, new intakes, seen on-site by the designated health authority, and/or any other pertinent medical events.

There were no applicable youth requiring immunizations; however, policy and procedures outline the AET provides an opportunity for parental consent to be obtained for missing vaccinations. At the time of signing the AET, the parent/guardian shall be provided with the relevant Vaccine Information Statements (VIS) to inform them of the potential risks and side effects. When the parent/guardian does not consent to the vaccinations, the Parent Notification of Health-Related Care: Vaccination/Immunizations form is sent with the required VIS to obtain consent. There were no applicable reviewed healthcare records of the parent/guardian not consenting due to religious reasons. Program practice is for the nursing staff to pull each youth's immunization record from the Florida Shots website and review each youth's education record within the first week of admission and have the designated health authority document a review of the record. This practice was confirmed by nursing staff in an interview.

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

The program maintains a written policy and procedures ensuring each youth receives a routine healthcare screening and evaluation upon admission and ensure a healthcare admission rescreening shall be completed each time the physical custody of the youth changes and are subsequently returned or readmitted to the program. A review of five youth healthcare records supported each youth received an initial admission screening utilizing the Department's Facility Entry Physical Health Screening (FEPHS) form. All admission screenings were completed by a registered nurse (RN). An interview with nursing staff indicated a nursing assessment is conducted immediately following the initial search of the youth's arrival. The registered nurse notifies the designated health authority (DHA) by telephone or verbally, if on-site, of the youth's history and identified chronic condition and documents the notification in the nursing admission chronological notes which is filed in the youth's healthcare record in the practitioner's chronological note section. Referrals are documented in the physician's log. None of the five reviewed healthcare records were applicable for a change in physical custody.

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

The program maintains a written policy and procedures establishing a system whereby all youth shall be oriented to the healthcare system upon admission or the next available opportunity. The health education shall be provided by the healthcare staff, in writing, and during an individual session with the youth to ensure youth with identified disabilities can understand the information provided. If a youth is presented with cognitive deficits, the teachers in the program shall provide information as to how to present the information to the youth who are impaired. A review

of five youth healthcare records validated each youth received a healthcare orientation on the day of admission, as documented on the Department's Health Education Record form. Each youth received a health education packet specifically designed for adolescents. Youth and nursing staff signed the health education packet acknowledging the training was conducted and the youth reviewed and understood the information. In addition to the admission health orientation, youth received health education throughout their stay documented in the healthcare record. Five reviewed healthcare records supported this practice.

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

The program's practice is for the designated health authority (DHA) to be notified by telephone, or verbally if on-site, of all admissions. In addition, when a youth is admitted on prescribed psychotropic medications, the psychiatrist is notified by telephone. Nursing staff document the notification on the Admission Progress Note form. The nurse signs the form and the DHA signs the form at the next on-site visit. A review of five youth healthcare records reflected the DHA was notified by telephone and the Admission Progress Note form was filed in the practitioner's section of each healthcare record.

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

The program maintains a written policy and procedures ensuring nursing staff shall complete the Department's Health-Related History (HRH) form prior to the Comprehensive Physical Assessment (CPA). A review of five youth healthcare records supported a new HRH was completed for each youth within seven days of the youth's admission. Reviewed practice validated the HRH was completed on the same day of each admission. The nursing staff provided their written signature on the HRH. The DHA documented a review of the HRH on the completed CPA. An interview with nursing staff confirmed the practice and indicated the HRH is completed whenever any new significant medical event or change occurs and then annually, thereafter.

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

The program maintains a written policy and procedures ensuring each youth receives a physical health evaluation after admission and prior to any participation in sports, exercise, or any other strenuous activity. The program maintains a written policy and procedures ensuring each youth receives a routine healthcare screening and evaluation for latent or active tuberculosis. A review of five youth healthcare records reflected the program utilizes the Department's standardized Comprehensive Physical Assessment (CPA) form. All CPAs were completed by the designated health authority (DHA). All sections of the CPA were completed in full utilizing "O" with no applicable "X" and included the appropriate medical grade of one through five. None reviewed CPAs completed sections numbers twenty-three, twenty-four, twenty-five, or twenty-six (pelvic and rectum examination); however, each documented not clinically significant on the CPA.

Reviewed documentation confirmed the Department's Problem List was updated for each youth throughout their stay, when applicable.

A review of five youth healthcare records supported each youth had at least one verified tuberculin skin test (TST) documented on the CPA within the last year to determine exposure to tuberculosis. In addition, as part of the healthcare admission screening, nursing staff utilize the Department's Facility Entry Physical Health Screening (FEPHS) form to conduct a tier I tuberculosis screening. All tier I tuberculosis screenings were conducted on the day of admission for each youth. Reviewed documentation found the results of the TST were documented on the Department's Infectious and Communicable Disease (ICD) form, and on the program's Tuberculosis Skin Test/Purified Protein Derivative (PPD) form. Nursing interviews indicated nursing staff review the Department's Juvenile Justice Information System to ensure there is a documented TST and to ensure the TST is current and documented, as required. The nursing staff also utilizes a tracking log to monitor TST/PPD due dates. There were no youth in the program with symptoms suggestive of active TB. Program procedures outline if the screening indicates the youth has symptoms suggestive of active TB, the youth are not placed in the general population until medically assessed by the DHA.

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

The program maintains a written policy and procedures ensuring all youth admitted shall be clinically screened and medically evaluated for sexually transmitted infections (STI). The designated health authority (DHA) shall then decide based on the screening tool and medical evaluation to order testing for sexually transmitted diseases/infections. A review of five youth healthcare records reflected two youth were identified as sexually active; therefore, one additional healthcare record was reviewed. Documentation supported each youth was clinically screened and evaluated for STIs utilizing the Sexually Transmitted Infectious Screening form. Each youth was referred to the DHA for further evaluation and testing was ordered and performed for each youth. Test results were filed in the lab section of the healthcare record and the screening results were documented on the Department's Infectious and Communicable Disease (ICD) form for all three youth. There were no applicable youth who were out of the Department's custody for over thirty days and/or required a rescreening due to symptoms present. Nursing interviews confirmed the program's practice.

The program maintains a written policy and procedures ensuring all youth at risk for human immunodeficiency virus (HIV) infection are offered counseling, testing, education, prevention counseling, and a referral for medical treatment, as indicated. A review of five youth healthcare records supported each youth was offered the opportunity to receive counseling and testing for HIV. The program utilizes a site-specific HIV Risk Assessment and a referral for testing is based on the assessment results. Youth who consent to receive counseling and testing sign the Department's Human Immunodeficiency Virus (HIV) Antibody Test Youth Consent form. A review of five youth healthcare records reflected four youth consented for testing. Prior to the COVID-19 pandemic, the Broward County Health Department conducted all HIV testing and pre and post-counseling on-site. Due to the COVID-19 pandemic, the Broward County Health Department is no longer going on-site; therefore, the program utilizes the designated health authority (DHA) to provide pre and post-counseling and utilizes a local laboratory to conduct the testing. Reviewed youth healthcare records validated when youth received pre-counseling, testing, and post-counseling, the youth's Health Education Record form was updated. The

results were placed in a sealed envelope marked, “Confidential” with the youth’s name and test date documented on the outside of the envelope. Nursing staff interviews indicated the confidential results are given to the youth upon discharge. Nursing staff maintain a HIV Testing Tracking Log to document the youth’s name, Department identification number, date refused testing (if applicable), date of testing, pre-testing date, post-testing date, and provider name. Five interviewed youth indicated they can request HIV testing.

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

The program maintains a written policy and procedures ensuring all youth shall be able to make sick call requests and have complaints treated appropriately through the sick call system. The program identifies sick call as the official method for a youth to request healthcare services for an illness or injury. Sick call care, including dental complaints, shall be available to all youth. Sick call care is provided by licensed healthcare professionals, pursuant to the scope of practice and according to the protocols approved by the designated health authority (DHA). The sick call process is intended to provide care in response to complaints of illness or injury of non-emergency nature, but which requires some form of assessment and/or decision-making by a licensed nurse and/or licensed physician. Each youth is oriented to the program’s sick call process upon admission. The program maintains independent contractor agreements with a State of Florida licensed dentist and a State of Florida licensed optometrist. The dentist’s license expires February 28, 2022 and the optometrist’s license expires February 28, 2021.

The program offers youth the opportunity to make a sick call request, seven days a week, twice daily, conducted by the licensed nursing staff. Each day, sick call is conducted at 10:00 a.m. and 2:00 p.m. A review of five youth healthcare records found two youth completed a Sick Call Request form at least once during their stay; therefore, an additional applicable youth healthcare record was received. The licensed registered nurse (RN) documented the treatment and/or services provided to the youth during the sick call event on the Sick Call Request form. There were no applicable youth who presented a similar sick call complaint three or more times within a two-week period. Reviewed healthcare records indicated each sick call incident was documented on the Sick Call Index and Sick Call Referral Log and the completed forms were filed in the healthcare record. When a licensed healthcare staff is not on-site, all Sick Call Request forms shall be submitted to a shift supervisor for review. The shift supervisor will determine if the sick call requires immediate attention. Program practice is for the shift supervisor to call the RN for all sick call requests when licensed medical staff are not on-site. The DHA is on-call and available for consultation to determine if the sick call requires immediate attention and/or for instructions. Any youth complaining of severe pain, including dental, which a staff member is unfamiliar and cannot determine the severity, shall be treated as emergencies and require immediate referrals to a licensed healthcare professional. All staff supervisors received medical technician training delivered by the RN and an interview with the RN indicated refresher training is provided annually. The program maintains a sick call box mounted to the wall located outside the medical clinic in the main hallway. The box is monitored throughout the day by nursing staff and complaints are triaged for urgency to be evaluated. All youth are seen within twenty-four hours of submission. There were no sick calls during the annual compliance week; therefore, observation of a sick call could not be conducted. Five interviewed staff

indicated nursing staff conducts sick call. Five youth were interviewed and four reported being seen immediately after a call request and one youth stated they never made a sick call.

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

The program maintains a written policy and procedures ensuring there is a written plan to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed. Staff must be able to respond to unexpected illnesses, accidents, or conditions which require immediate attention or an immediate professional assessment to determine their severity. A review of five youth healthcare records found three youth requiring episodic and/or first aid care during their stay in the program, with one youth having two separate incidents. All treatment services were provided by nursing staff and the nursing progress notes clearly documented treatment services rendered in standard narrative charting and/or problem-oriented subjective, objective, assessment, and plan (SOAP) elements. Nursing staff also maintained an Episodic/First Aid/Emergency Care Log documenting all incidents of care by date, name of youth, Department identification number, injury/emergency, treatment rendered, registered nurse initials, and whether the youth was referred to the designated health authority (DHA). Nursing interviews confirmed the program's practice. Episodic care was provided to one youth by trained non-healthcare staff. Reviewed documentation supported the Department's Report of On-Site Care by Non-Healthcare Staff form was completed in full and provided to license nursing staff for review the following morning. Youth who are sent off-site for emergency care are tracked in the nursing progress notes and documented on the Episodic Log.

The program maintains a written policy and procedure ensuring the program-based automated external defibrillator (AED) is properly managed and administered to persons eight years of age and older who experience sudden cardiac arrest. The program maintains one AED located in master control. Nursing staff ensure the AED is functioning adequately and include the inspection of the batteries and pads to ensure they are in working order. The AED procedures are audio as observed and as described by the nursing staff. Written AED procedures are affixed to the wall on each end of the main hallway. Reviewed documentation supported AED batteries expire on October 31, 2022, and pads expire on May 20, 2021. The batteries were last changed on January 23, 2019 and the pads were changed on January 23, 2019. Observations of the AED during the annual compliance review validated it was operational.

The program has seven first aid kits located in master control, the medical clinic, the kitchen, both laundry rooms, and two which are stored in master control for use in the program's vans used for transport. Reviewed documentation for seven first aid kits, including two kits used during youth transport, reflected each contained the required items and all items were current and within their expiration period. A list of the items contained in each first aid kit were maintained on an inventory log with the date of the weekly inspection along with nursing staff initials. The first aid kits were checked weekly to ensure they are secure and stocked, and contents are reviewed monthly for expiration dates. Three first aid kits were observed, and each contained the required items. The program maintains one full suicide response kit located in master control and observation found it contained a knife-for-life, wire cutters, and needle nose pliers. The AED and suicide response kit were checked monthly by nursing staff to ensure each are adequately supplied and in operating order.

Reviewed training records supported all non-healthcare staff who have direct contact with youth maintained current certifications in first aid, cardiopulmonary resuscitation (CPR) with AED.

Nursing staff maintained current certifications in CPR and AED. Reviewed training records supported all staff have been trained in the administration of the epinephrine autoinjector; however, only supervisory staff are permitted to administer it. The program conducts announced and unannounced emergency medical drills at least twice monthly on each shift. Reviewed documentation supported an annual calendar is maintained identifying the drill conducted. A review of drills conducted for the last twelve months supported drills were conducted at least twice monthly on each shift and included CPR/AED demonstration at least quarterly. Postings informing staff of their right and responsibility to call 9-1-1 were observed during the annual compliance review. The program reported emergency telephone numbers were located in the supervisor's and the medical clinic accessible to staff but inaccessible to youth.

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

The program maintains a written policy and procedures ensuring for timely referrals and coordination of medical services to an off-site healthcare provider. Evaluations conducted off-site shall be recorded on the Department's Summary of Off-Site Care Form. The designated health authority (DHA) reviews, signs, and dates the off-site care instructions. A review of five youth healthcare records found none required off-site care and/or emergency care; therefore, three additional applicable healthcare records were reviewed. Each off-site care event was documented in the healthcare records. The reviewed youth healthcare records indicated each youth was under eighteen years of age and the parent/guardian was notified. The Summary of Off-Site Care Form was completed for each youth and was filed in the appropriate section of the healthcare record. Reviewed documentation supported the DHA reviewed each completed Summary of Off-Site Care Form and discharge paperwork as evidenced by signature and date. One youth required follow-up care and received services as prescribed. An interview with nursing staff indicated the registered nurses track follow-up testing, referrals, and appointments on the Medical Services Tracking form, Physician's Weekly Clinic List Form, and Sick Call / Referral Log Form.

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

The program maintains a written policy and procedures ensuring youth who have been identified with a chronic illness receives regularly scheduled evaluations and necessary follow-up treatment. The purpose of the periodic evaluation is to ensure the youth requiring ongoing treatment or who have experienced changes in condition or treatment regimen are adequately monitored. The frequency of the periodic evaluation is determined by the youth's condition, clinical needs, and clinically appropriate medical standards. A review of five youth healthcare records indicated none of the youth were admitted with an identified chronic condition, as documented on the Facility Entry Physical Health Screening (FEPHS) form; therefore, three additional applicable records were reviewed. All three youth were classified with a medical grade of two through five. Each youth was currently undergoing treatment for physical health condition which included one youth with a body mass index greater than thirty. One of the three applicable youth was also taking psychotropic medication and was seen by the psychiatrist as required. The program maintains a youth roster and tracking log of youth requiring periodic

evaluations identifying the youth's name, date of admission, whether youth was admitted with prescribed medication, chronic condition, date of last visit, and next visit date. Reviewed records reflected each youth received periodic evaluations as required. An interview with the designated health authority (DHA) indicated chronic conditions are monitored at least every ninety-days unless medically indicated to be sooner. An interview with nursing staff reported youth identified with a chronic condition are placed on the medical tracking log to ensure the DHA follows-up with each applicable youth. The DHA indicated the nursing staff and DHA meet regularly to discuss important treatment plans for youth. In addition, the DHA indicated formal quarterly meetings are conducted with the facility administrator, nursing staff, clinical director, consultant pharmacist, and DHA to discuss the youth in the program. In an interview, the psychiatrist indicated the youth are evaluated every thirty days. There was no indication of lapses in care or missed periodic evaluations. The program did not have any youth taking anti-TB medication or who were pregnant. Reviewed documentation supported the Department's Problem List was updated as required.

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

The program maintains a written policy and procedures ensuring medical staff shall verify any medications arriving with a newly admitted youth and continue all currently prescribed medications. When a youth arrives to the program with medication(s) or order/prescriptions for medication(s), the healthcare staff will conduct a preliminary assessment and interview to determine the medication is verified and documented. Nursing staff complete the Facility Entry Physical Health Screening (FEPHS) to determine medical needs. The signed Authority for Evaluation and Treatment (AET) serves as the authority to continue the present medication(s) and administer the medication(s) as ordered. An interview with nursing staff indicated only a registered nurse completes the admission and any applicable medications are verified with the youth's medical records and the youth's parent/guardian. A review of five youth healthcare records indicated none were admitted into the program on prescribed medication; therefore, three additional applicable healthcare records were review. Nursing admission notes documented each youth's current medication and notification to the designated health authority (DHA). Program practice is to notify the DHA for all youth admissions. Reviewed documentation reflected the DHA or psychiatrist resumed the prescribed medication for each youth. Reviewed Medication Administration Records (MARs) validated the practice. All medication is verified and there were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian. Reviewed documentation reflected all medications have a current, valid order, and are administered pursuant to a current practitioner's order. The program does not utilize restrictive housing; therefore, all medications are administered with consistent practice. Each reviewed youth healthcare record supported the prescribed medication was continued, discontinued, changed, or a new medication was ordered. In each instance, the practitioner's order clearly documented the medication and dosage. Oral prescription medications are administered, according to instructions. All staff administering medications shall have knowledge or are informed of the common side effects and precautions of prescribed medications. Three reviewed youth healthcare records found each youth had a Medication Administration Record (MAR) outlining over-the-counter medications approved through the Authority for Evaluation and Treatment (AET) form. The medication was administered in accordance with the approved protocols and physician's order. All three youth were prescribed medications and reviewed documentation supported the program utilizes a pre-

printed Guardian Pharmacy MAR to document administration of medication. Each reviewed MAR documented the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade, and a current picture of the youth. All three youth were taking prescribed medications upon admission and the initial MAR matched the medication listed. Observations found the medications are procured through Guardian Pharmacy. The medications are maintained in blister packs documenting the number of pills in each prescription order. Procured medications are administered by nursing staff. The youth's MAR and/or Individual Controlled Medication Inventory Record is updated after each administration. Shift-to-shift inventories of controlled medications are conducted by two registered nurses (RN). If there is only one RN on-site, the inventory is completed by the RN and a shift supervisor. All three reviewed MARs supported the youth received the medication(s) as prescribed. The MAR clearly indicated medication start and stop dates. Licensed staff initialed the MAR for each administered medication entry. Nursing staff maintain locked cabinets in the medical clinic with OTC medications listed on the Authority for Evaluation and Treatment (AET) form for the trained non-licensed staff to utilize when nursing staff are not on-site. The trained non-licensed staff are permitted to assist youth in OTC medications when nursing staff are not on- site. All OTC medications are stored in the medical clinic accessible to trained non-healthcare staff to dispense in the absence of licensed medical staff. There were no indications of lapses and/or errors in the medication administration. A review of the Department's Central Communications Center reports validated there were no incidents of missed medications. Nursing staff documented side effect monitoring on the MAR daily each time medication was administered. None of the three youth were applicable for a refusal of medication. Observation of one medication administration by nursing staff validated the medication cart was secured when not in use. Observations of the medication cart found it clean and organized with medications separated. The Six Rights of Medication Delivery/Administration was maintained for each youth. The program maintains a written policy and procedures ensuring all controlled substances shall be inventoried, stored, and documented, as required by the Board of Pharmacy and Department requirements. Program procedures outline all controlled substances are to be maintained in the securely locked box within the securely locked medication cart located in the medical clinic. Observations during the annual compliance review and an interview with the nursing staff validated the practice. The program did not have any controlled substances on-site during the annual compliance review. The program maintains one refrigerator in the medical clinic for the storage of medication. There was one applicable medication requiring refrigeration during the annual compliance review week which was stored in the refrigerator. Five youth were interviewed, and four reported not taking any medication. One youth was taking prescribed medication and stated it was administered by nursing staff or the medical doctor.

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

The program maintains a written policy and procedures ensuring all medications shall be identified and secured in a locked area designated for storage of medications. Observations found all medications securely stored in the medical clinic inaccessible to youth. All non-controlled medications were stored in a separate, secure, locked medication cart and a small amount of over-the-counter medications were placed in the locked medical cart for trained authorized non-licensed staff to administer, if needed. Narcotics and other controlled medications are securely stored in a locked box located within the medication cart. Oral medications were not stored with injectable or topical medications. The program maintains one

refrigerator for medications. There was one medication requiring refrigeration during the annual compliance review week and was observed in the refrigerator. The program securely stored sharps and syringes separate from medications. The program maintains a written policy and procedures ensuring all chemical products, medicines, and medical and dental instruments assigned to the medical department are securely stored, regularly inventoried, disposed of and properly maintained in accordance with federal and state laws. Reviewed documentation and nursing interviews confirmed all over-the-counter (OTC) medications are inventoried at least weekly. Program practice is for OTC medications to be inventoried using a perpetual daily inventory and verified weekly. Perpetual inventories with running balances are maintained on all controlled substance with a shift-to-shift inventory conducted by two registered nurses (RN). If there is only one RN on-site, the inventory is completed by the RN and the shift supervisor. Syringes and sharps are counted through a perpetual inventory and are verified weekly. The program contracts with Guardian Pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist license expires February 28, 2021. Reviewed documentation supported the consultant pharmacist conducted monthly on-site inspections and maintained a consultant pharmacist inspection log and consultant pharmacist monthly inspection report. The program maintains written procedures for the disposal of narcotics and other controlled substances. Program practice is for the consultant pharmacist and registered nursing staff to dispose of the medication by placing the medication in an All-Purpose RX Destroyer System bag and document the disposal on the Disposal Log and on the Controlled Medication Inventory Record. All non-controlled medications are sent back to Guardian Pharmacy for credit. Observations conducted during the annual compliance review week supported three youth prescribed medications inventories were accurate. Three OTC medications were reviewed, and the inventories were accurate. Three sharps were reviewed, and inventories were accurate. A review of the program's counts from the past six months validated no discrepancies were identified with the counts.

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

The program maintains a written policy and procedures ensuring there is an approved plan for exposure control and infection control ensuring staff, youth, volunteers, and visitors are not exposed to infectious and communicable diseases. The program's Exposure Control Plan/Infection Control Plan includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the guidelines and recommendations of the Centers for Disease Control and Prevention (CDC), Occupational Safety and Health Administration (OSHA) federal regulations, and State of Florida guidelines. The plan was reviewed and approved by the facility administrator (FA) on October 27, 2020, and designated health authority (DHA) on September 25, 2020. The plan includes common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, and tuberculosis. In addition, the plan includes Hepatitis A, B, C, and human immunodeficiency virus (HIV) infectious diseases caused by blood-borne pathogens. The plan outline outbreaks in pediculosis and/or scabies, outbreaks or epidemics caused by other infectious agents, food-borne illnesses, bio-terrorist's agents, chemical exposures, Methicillin-Resistant Staphylococcus

Aureus (MRSA), and other emerging antibiotic-resistant micro-organisms. The program maintains procedures for staff to adhere to universal precautions, and the program provides staff with the opportunity for Hepatitis B immunizations and access to protective equipment. The program reported instances of positive and/or pending cases of COVID-19 and quarantine to the Broward County Health Department, CDC, and/or the Department's Central Communications Center (CCC), as required. The program's plan has a comprehensive process for needle stick post-exposure evaluation. In the event of an incident, the FA has a process in place to establish a separate file containing all documents for youth and staff who have experienced a facility/occupational exposure. The program's Exposure Control Plan/Infection Control Plan is written in accordance with the Occupational Safety and Health Administration (OSHA) standards. The plan includes risk assessment and methods of compliance. There were no documented instances of staff having experienced a facility or occupational exposure since the last annual compliance review. The plan is accessible to all staff and is maintained in the medical clinic, master control, and in the administrative offices.

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

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

4.19 Licensed Medical Staff (Critical)	**Satisfactory Compliance**
The program shall provide access to prenatal care for all pregnant youth. Health Education shall be provided to both youth and staff.	

The designated health authority (DHA) is clinically responsible for all healthcare services provided to each youth at the program. Daily clinical care is performed by licensed medical staff in accordance to developed and authorized protocols, facility operating procedures, and Florida Administrative Code. In addition to the DHA who is a medical doctor the program utilizes two full time registered nurses (RN) who hold clear and active licenses in the State of Florida. One of the RNs is also the health services administrator. Both RN's licenses expire on July 31, 2022. Reviewed training records for licensed medical staff supported each has current certifications in cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED) which is pursuant to the program's contract.

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 maintains a written policy and procedures pertaining to youth supervision. The program promotes safety and security by keeping active supervision of youth to include interacting positively with youth, engaging youth in a full schedule of constructive activities, closely observing behavior of youth, redirecting inappropriate behavior, and consistently applying the program's behavior management system (BMS). The program has a daily activity schedule posted in the youth living areas and hallways. Youth and staff observations were conducted each day throughout the week of the annual compliance review during class, lunch, recreation time, and movement (from classroom to classroom and from classroom to cafeteria). Staff were positioned to ensure proper supervision and to ensure there were no physical obstructions in their view of the youth. Youth-to-staff ratios were observed to be compliant with the program's contract of one staff for every eight youth. Informal interviews were conducted with direct care staff each day of the annual compliance review and reflected staff were aware of how many youth they were supervising and understood the program's procedures to take if there is a discrepancy in youth counts. Staff reported when a youth count cannot be verified, all movement is stopped, no one may enter or leave the secure area, a recount of all youth is conducted, and staff must notify master control or the shift supervisor. Formal and informal youth counts are consistently completed throughout each day. Observations found the program staff interacting positively with the youth and followed the program's BMS.

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

The program maintains a written policy and procedures outlining the behavior management system (BMS). The BMS is outlined in the youth handbook, offering a detailed explanation of the program's system, rules, and expectations. An interview with the facility administrator (FA) confirmed the program's BMS has not changed since the last annual compliance review. The BMS is a four-level system which coordinates a system of promoting, monitoring, recognizing, and rewarding a youth's progress. Each youth enters the program on an orientation level prior to starting the BMS and progresses their way up the four levels. The four levels of the BMS includes junior varsity, varsity, college, and pro levels. The BMS provides opportunities for positive reinforcement and individual recognitions for pro-social behaviors and accomplishments, positive behaviors, and promotes conflict resolution while minimizing separation of youth from the general population and routine activities. The BMS provides immediate on-going feedback to youth related to their behavior, promotes positive behavior,

teaches youth alternative ways and skills to solve problems and outlines the program's rewards and privileges. The BMS rewards and privileges is on a point system and includes responsibilities, expectations, and level advancement. The point system addresses inappropriate behavior which directly correlates with the seriousness or severity of the behavior. BMS behaviors will be addressed immediately using de-escalation techniques to prevent a crisis from developing and when committing major rule violations can lead to a loss of privileges and/or the suspension of a level for a determined period. In addition, youth will be required to complete a therapeutic activity to address the undesired behavior. Reviewed documentation reflected daily point sheets were totaled each day and at the end of each week. The program's student council members, along with administrative staff, develops and maintains a monthly nightly incentive privilege calendar filled with fun and meaningful activities as a system for positive reinforcement opportunities. Youth must earn the appropriate number of points each day to earn their nightly privilege. Rewards include, but are not limited to, canteen, honor room privileges, later bedtimes, snacks, games, movies, and verbal praise. In addition to the nightly privileges, the program has an incentive each Monday and Friday labelled "Marvelous Mondays" and "Fantastic Fridays." On Mondays, an incentive is given to any youth who went the entire weekend without incurring any major rule violations. On Fridays, an incentive is given for any youth who goes the entire week without receiving any major rule violations and earns their daily points each day for the week. The program also has a system called, "GOTCHA." This system is utilized to catch a youth doing the right thing while in the program. When youth are exhibiting appropriate behavior, such as displaying empathy to their peers, demonstrating leadership, encouraging peers to make good decisions, following staff's first prompt, picking up trash without being told, displaying good manners, and/or demonstrating patience, staff may issue them a "GOTCHA" award. Each time a youth receives a "GOTHCA" award, the youth's name is placed in a raffle for a reward drawing at the end of the month. Two youth are selected each month from the dorms to have lunch of their choice with a treatment team member.

A review of five youth case management records confirmed each youth was oriented upon admission through the program's youth handbook which includes a detailed outline of the BMS. Reviewed documentation confirmed each youth signed the youth handbook acknowledging receipt upon admission into the program. A review of five pre-service training records and five in-service training records confirmed each staff was trained in the program's BMS. The program provided training and documentation of sign-in sheet of staff members from the Broward County School District receiving training on the program's BMS. During the annual compliance review, observations confirmed the program has postings of the BMS throughout the facility which is accessible to all youth and staff. A review of the program's facility operating procedures (FOP), coupled with an interview with the FA, confirmed fidelity checks are used during daily and monthly staff and treatment team meetings to monitor rewards and consequences/punishments to ensure rewards outnumber consequences at a minimum ratio of four-to-one positive-to-negative consequences. Five interviewed youth reported rewards includes later bedtimes, extra telephone time, snacks, canteen, games, movies, personal hygiene items, and verbal praise.

5.03 Behavior Management System Infractions and System Monitoring	Satisfactory Compliance

The program's behavior management system (BMS) is designed to maintain order and security, provide constructive discipline and a system of positive and negative consequences to encourage youth to meet expectations for behavior, provide opportunities for positive reinforcement and recognition for accomplishments and positive behaviors, promote dialogue and peaceful conflict resolution, and minimize separation of youth from the general population.

Supervisors shall monitor staff implementation of the behavior management system (BMS), and ensure the use of rewards and consequences are administered fairly and consistently in application among all staff.

The program has a specific written behavior management system (BMS). The BMS provides for positive and negative consequences in a ratio of four-to-one positive-to-negative consequences. The system makes provisions for staff to explain to the youth the reason for any sanctions imposed, youth to explain their behavior, and gives staff and youth the opportunity to discuss the behavior's impact on others. Consequences and sanctions for rule violations are directly related to the seriousness of the inappropriate behavior and are clear and consistently imposed. All program infractions are reflected on the applicable youth's daily point cards. The BMS is not used to increase a youth's length of stay. The program does not utilize room restrictions as a form of imposing sanctions for inappropriate behavior. A formal interview with the facility administrator (FA), coupled with a sample of randomly selected staff position descriptions, were reviewed and reflected the position descriptions specified implementation of the BMS as a job requirement. Reviewed documentation confirmed staff received an initial ninety-day performance evaluation followed by an annual evaluation thereafter, which includes an evaluation of the staff's implementation of the BMS. The FA reported the BMS is monitored in the program's monthly meetings and in performance evaluations to ensure the BMS is administered fairly and consistently. Program management provides updates and feedback on the staff's use of rewards and consequences regarding the BMS during staff meetings and during shift briefings. Five staff were interviewed and stated supervisors provide feedback to staff regarding the implementation of the BMS immediately or when having knowledge of a situation. Five interviewed staff confirmed rewards include but are not limited to later bedtimes, extra telephone time, snacks, canteen, games, movies, personal hygiene items, and verbal praise. Five interviewed youth confirmed they are never allowed to punish another youth. Four youth rated the program's BMS as "good," and one youth rated it 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 a written policy and procedures regarding ten-minute checks. All staff shall observe youth at least every ten-minutes while in their sleeping quarters either during sleep time or at other times, such as during an illness. Staff shall conduct observations in a manner to ensure the safety and security of each youth and shall document real time observations manually or electronically. The program utilizes a ten-minute check log to document the check while the youth are in their sleeping quarters. The facility administrator (FA) confirmed the program is equipped with fifty-eight digital closed-circuit televisions (CCTV) cameras hardwired

to four digital video recorders (DVR) to aid in ensuring security and facility control. All cameras were operational at the time of the annual compliance review. The video system stores video recordings for up to thirty-days. If there are any issues with the cameras, the program utilizes Florida State Security for service repair. Reviewed documentation of the program's ten-minute check log forms reflected staff documented the time of the room check in real time, as well as the staff's initials on the ten-minute check log sheets verifying who completed the room check. A review of ten-minute check logs from six randomly selected days and times from two different shifts were reviewed and compared with corresponding video recordings. Reviewed documentation verified checks were conducted at least every ten-minutes. Five interviewed staff confirmed room checks are conducted every ten-minutes, while one staff stated room checks occur every five-minutes for non-suicidal youth.

5.05 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

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

The program maintains a policy and procedures to ensure youth are continuously accounted for through a system of physically counting youth at various times throughout the day. The program conducts and documents youth counts minimally at the beginning of each shift, after each outdoor activity, and during emergency situations such as riots or escapes. The program maintains a chronological record of events as they occur, if an event disrupts the safety and security of the program, or as soon as it is feasible after order has been restored. The program tracks daily census information including, at a minimum, the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program. According to the program's policy, staff are to conduct formal and informal counts of youth throughout the day and the program has a dry erase board in master control to track the program's census. If at any time staff cannot account for the whereabouts of a youth or discrepancies are found between youth counts and census information, the program reconciles immediately and takes follow-up action by stopping all movement and conducting a recount, as needed. Reviewed documentation confirmed the program conducted counts at the beginning of each shift, after each outdoor activity, during emergency situations, during lunch, breakfast, movement from classrooms, and temporarily away from the program. Five interviewed staff confirmed the importance of emergency counts and how often counts must be performed, which aligned with the program's policy. A review of the program's Continuity of Operations Plan (COOP), outlining youth count requirements, confirmed the program is in compliance with the program's policy and procedures.

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 maintains a written policy and procedures requiring logbooks to provide procedures and documentation for a daily account of routines and emergency situations involving youth throughout the day in all areas of the facility. The logbook is maintained in master control. A review of the current and previous logbooks found the ledgers to be a bound logbook with numbered pages. Reviewed documentation reflected population counts, perimeter checks, emergency situations, incidents, transports, removal of youth from population, admissions, releases, Department's Central Communications Center (CCC) calls/incidents, and Florida Abuse Hotline calls/incidents were documented since the last annual compliance review. Reviewed documentation of randomly selected days within the logbooks reflected each entry was legible and written in ink with no erasures or white-out. The program conducts staff briefings prior to the beginning of each shift which are recorded in the logbook. Observations of a shift change meeting reflected incoming staff were briefed on the previous shift's occurrences and incoming staff signed and dated the shift report acknowledging receipt from the previous shift.

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 maintains a written policy and procedures outlining the key control system. The system in place maintains the control and use of keys which includes key assignment, restrictions on usage, inventory, tracking of keys, secure storage of keys and procedures addressing missing or lost keys, damage keys, and replacements. The program keys are located in master control within a secure locked key box and personal keys are locked in a secure cabinet located in the front lobby. When staff arrive to the program to begin their shift, they gain access to the facility through the front lobby and then report to master control to receive their assigned key, if applicable. Staff relinquish their personal keys to the assigned front lobby staff prior to entering the secure side of the facility. Restricted keys are maintained in the same locked cabinet as the program keys and only approved staff have access to the restricted keys. Approved staff include the nurses, maintenance, food services manager, case managers, and administrative staff such as supervisors and the facility administrator (FA). The program maintains a list of staff who are assigned permanent keys. Staff who are authorized to possess permanent keys must sign an acknowledgment form indicating a key identification number and the number of keys issued. Reviewed documentation of the current key inventory was compared with the keys in use and the inventory matched the actual keys in use. The master control operator and the FA were interviewed and advised damaged keys are turned over to master control and maintenance personnel then administration is notified to have the

key replaced. Staff must complete a damaged key form. The master control operator and the FA are advised if lost keys have not been found within two hours and the incident is reported to the Department's Central Communications Center (CCC). Five interviewed staff understood the key control processes including how keys are assigned, missing/lost keys, damaged keys, and restricted keys.

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

The program maintains a written policy and procedures in place to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, incoming and outgoing mail, and staff and youth. The program defines items and materials considered contraband when found in the possession of youth. Youth are provided with a list of contraband which includes sharp objects, escape paraphernalia, tobacco products, electronic or vaporless cigarettes, non-facility issued electronic equipment or devices, metals, personal non-facility issued cellular devices, unauthorized currency or coins, and non-facility issued keys. Upon admission to the program, each youth receives a youth handbook. Youth are notified of the unauthorized and illegal contraband and the consequences of possessing contraband. Observations conducted throughout the week of the annual compliance review found all staff and visitors including their bags were searched with an electronic wand prior to entry. A review of the program's policy, youth handbook, and visitor contraband list verified a list of the unauthorized items not permitted which includes personal cellular telephones, and devices capable of taking photos and/or audio/video recordings. A review of the master control logbook found unannounced room searches were conducted routinely and perimeter searches were conducted daily on each shift. Any contraband found is documented on an incident reporting form and in the facility logbook which includes the method of disposal. A review of daily incident reports and the safety perimeter check inspection reports for the past six months verified searches and facility checks were conducted daily on each shift. Any illegal contraband is turned over to the local police department. An interview with the facility administrator (FA) revealed the discovery of unauthorized contraband is confiscated, and either discarded, returned to the original owner, mailed to the youth's home, or stored and returned to the youth upon release.

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

The program maintains a written policy and procedures to ensure searches and full body visual searches are conducted in accordance with Florida Administrative Code (F.A.C.). Observations of youth searches prior to and after groups, as well as a new admission to the program found no contraband was confiscated. During the annual compliance review week, the program did have a transport, new admission, and youth returning from court. Parents/guardians are notified of searches during visitation in the parent/guardian intake letter, packet containing the youth handbook, and program rules which are mailed to the parent/guardian at the time of the youth's admission. Observations of searches conducted before and after youth movements were made and reflected youth are given instructions regarding the search. Youth were searched by a staff member of the same gender, conducted in a manner not to degrade the youth, and were based on the Protective Action Response (PAR) training manual. Five interviewed staff confirmed youth are searched after movement, upon return from off-campus activities, at random, and if a youth is suspected in possession of lost property. Five youth were interviewed and indicated searches occur when returning from off-campus, after outdoor recreation, when items are missing, after visitation, after meals, and after work detail. Youth also stated they are searched after something major is missing and after every family day.

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

The program has a written policy and procedures in place for vehicles and vehicle maintenance. The program has two Department vehicles utilized to transport youth at the program. The Department identifies one van as van number three and the other van as van number nineteen. Reviewed documentation related to both vans reflected both have all required maintenance, insurance, and registration documentation up-to-date. Reviewed documentation for van number three confirmed an annual inspection was completed on February 24, 2020 and documentation for van number nineteen confirmed the annual inspection completed on February 28, 2020. According to the facility administrator (FA), vehicle nineteen is sent out for quarterly inspections because vehicle nineteen is primarily used for court and intake and vehicle three is primarily used for outing and job interviews.

Observations of each vehicle used to transport youth found each vehicle was equipped with the appropriate number of seat belts, a seat belt cutter, a window punch, a fire extinguisher, and an approved first-aid kit. Observations made of van number three reflected it is not equipped with a safety screen separating the driver's compartment from the passenger's compartment. Observations of van number nineteen reflected it is equipped with a safety screen separating the front seat compartment from the passenger's compartment. During the annual compliance review week, there was one youth transported to the program and one youth transported off-site. Observations found youth and staff were wearing seat belts. A formal interview was

conducted with the FA who explained the transportations process step by step. Staff conducts a safety check on the van prior to transport, staff search youth prior to transport, and staff notify master control prior to leaving the facility. This process is repeated on the return to the facility. Observations of a random check of personal vehicles and facility vehicles confirmed the vehicles were locked when not in use.

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

The program maintains a written policy and procedures to ensure appropriate minimum staff-to-youth ratio for the safety and security of youth, staff, and the community when youth are transported outside of the facility. A review of the program's policy ensured compliance of all requirements outlined by the Department relating to transportation of youth and driver eligibility. Reviewed documentation, combined with an interview with the facility administrator (FA), confirmed the program has a minimum of two staff for each transport and a staff always occupies the rear passenger's seat area. Staff are not allowed to transport youth in personal vehicles nor are youth allowed to operate staff vehicles. The program maintains a list of staff who are approved to transport youth and an eligible driver's license. Driver's license checks are conducted on all staff upon hire. If designated as a transport staff, the staff's driver's licenses are checked monthly by the FA. An interview with the FA confirmed during any transport, staff are provided a program-assigned cellular telephone to carry with them on transports to communicate during emergency situations. The program's practice is for staff to call the program upon arrival to destination and upon leaving destinations. In addition, the program's staff take a full-length picture of the youth to be aware of the youth's current clothing and appearance in case of an emergency. The program stores an emergency binder in each van which contains current copies of the youth's Authorization for Evaluation and Treatment (AET) forms with face sheets for all current youth in the program. Observations of a random check of personal vehicles and facility vehicles confirmed the vehicles were locked when not in use. The FA explained the practice of the staff-to-youth ratio of one staff to every five youth is maintained during all transports.

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

The program maintains a written policy and procedures requiring weekly safety and security checks of the physical plant, grounds, and perimeter. The program's policy meets all requirements of Florida Administrative Code. The facility administrator (FA) or designee is responsible for conducting safety and security audits every seven days. Reviewed documentation reflected staff utilized the Department's Facility Security Audit and Safety Inspections form to document the weekly completions of audits. Records reflected this practice was consistently completed for a period covering the past six months. A formal interview with the FA, combined with reviewed documentation, confirmed the FA reviewed all weekly safety inspection forms each week.

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

The program has a written policy and procedures to ensure youth do not use tools or equipment as weapons or security breaches. The procedures address the issuance, inventory and control of equipment and tools. The procedures indicate staff shall report any discrepancies to the facility administrator (FA) or designee for immediate follow-up action. The program prohibits tools such as machetes, bowie knives, or any long blade knives. The program's policy addresses missing and/or lost tool procedures. According to the assistant program director (AFA), the program identifies the physical plant manager as the designated tool control manager. The physical plant manager replaces and disposes of tools, as needed. The physical plant manager completes a Tool Replacement form and submits it to the FA for approval to purchase a replacement. No tools were required to be replaced during the annual compliance review period. Observations of tools found each tool was securely stored when not in use, marked for easy identification, and inventoried prior to issuance and return for work . Observations of the tool storage area indicated it was organized. The physical plant manager confirmed youth are not allowed to utilize any class A tools. A review of five staff training records and five youth case management records indicated staff and youth are trained on the safe use of class B tools. Five interviewed youth confirmed using mops and brooms. Two of the five interviewed youth stated they use scrub brushes.

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 written policy and procedures to ensure youth use tools safely and are supervised appropriately to prevent injuries to themselves, other youth, and staff. The program's policy requires a minimum ratio of one staff for every five youth during activities involving tools, except in the case of disciplinary work projects involving tools which require a minimum ratio of one staff for every three youth. The program completes a Youth Risk Assessment on each youth upon admission and every thirty days thereafter. Reviewed documentation confirmed assessments were completed on each youth prior to the youth utilizing class B tools. Observations of staff confirmed searches were conducted on youth who were issued a class B tool, and when tools were distributed and collected when youth concluded cleaning the hall floor. Five interviewed staff confirmed youth can use mops, brooms, and scrub brushes under staff supervision. Staff and youth are aware of the staff-to-youth ratio requirements during these activities.

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

The program has a written policy and procedures to address outside contractors which stipulates when an outside repairman or worker enters the program to perform a work project requiring the use of tools, the tools must be inventoried. The use and handling of the specific tools are restricted by the program to only the repairman. The program's policy requires tool checks upon the worker's arrival and departure, restricts youth access to the work area, ensures

immediate reporting of any tool the worker cannot locate, and follow-up if any tool is missing. Personal cellular telephones and/or equipment/electronic devices capable of taking pictures and/or audio/video recordings are prohibited in the secure area. The facility administrator (FA) and the assistant FA are the only individuals responsible for providing approval and/or permissions if such items are required. The program requires all outside repairmen or worker's entering the program to review and sign a contractor's agreement form and document their understanding of the agreement with the rules, requirements, and guidelines to which the repairman must adhere to while working on-site at the program. A selection of the completed project invoices submitted to the program by the vendor validated the outside contractors tools were inventoried prior to entering and when leaving the secure area of the facility. Each of the forms were signed by the outside contractor, as required.

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

The program has a written Continuity of Operations Plan (COOP) which was approved by the Department on March 17, 2020. The COOP requires the program to conduct fire, safety, and evacuation drills monthly on a random basis on each shift and unannounced fire drills once a month on each shift. Drills are to be conducted under diverse conditions when a majority of the youth are available. Program staff shall document drills on a program-specific Emergency Drills form. Each of the forms documented the beginning and ending times and the nature of the drills. Reviewed documentation confirmed the program conducted unannounced fire drills and COOP drills on each shift in accordance with the COOP. An interview with the facility administrator (FA) reflected fire drills and COOP drills are to be completed monthly for each shift. Five interviewed youth had been instructed on what to do in the case of a fire. Interviews conducted with five staff revealed they participated on various drills within the last twelve months including drill scenarios involving major disturbances, weather, bomb threats, chemical spills, flooding, escape, medical emergencies, and fires.

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

The program has a written Continuity of Operations Plan (COOP) which includes a coordinated disaster plan. The plan provides for the basic care and custody of youth in the event of an emergency or disaster and the continuation of services ensuring the safety of staff, youth, and the public. The plan outlines procedures whereby critical identifying information and a current photograph of all youth are easily accessible to verify a youth's identity, as needed, during the youth's stay in the program and in the event of an emergency evacuation. The plan was approved by the Department on March 17, 2020. The COOP is located in master control and is readily available to staff members. The program has identified the various locations within the

program where staff, youth, and visitors can easily access the plan. The COOP addresses phases of a disaster plan, as well as emergency management including preparedness, response, and recovery. The COOP addresses emergencies including fire prevention, bomb threats, evacuations, chemical spills, severe weather, and terrorist attacks. A review of the plan indicated alternative housing in the event the program must evacuate due to an emergency or disaster. An interview with the facility administrator (FA) confirmed a copy of the COOP is located in master control. Observations, including the FA interview, confirmed the program maintains critical identifying information for each youth in an administrative hard-copy file which is easily accessible and mobile in the event of an emergency, which results in the program relocating quickly or in the event needed information cannot be accessed electronically. A review of the administrative hard-copy file included each youth's name, a photograph, Department identification number, admission date, date of birth, gender, race, name, address, and parent/guardian contact information including name, address, telephone number of the person with whom the youth resides, and the relationship to the youth, and person(s) to notify in case of an emergency. In addition, the COOP requires the contact information of the youth's juvenile probation officer's (JPO) name, circuit/unit, names of committing judge, state attorney, and public defender or attorney of record. The hard-copy file further included the youth's committing offense and judicial circuit where the offense occurred, notation of whether the judge retains jurisdiction, victim notification contact information, if notification is required, physical description of youth to include height, weight, eyes and hair color, and any identifying marks, overall health status, including chronic illnesses, current medications and allergies, along with personal physician if known.

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 maintains a written policy and procedures to ensure strict control of flammable, poisonous and toxic items and materials. A complete inventory of all such items was conducted. All flammable, poisonous, and toxic materials are stored in secured areas inaccessible to youth. A review of the flammable, poisonous, and toxic items list verified the items were securely stored. Observations revealed the program maintains a list of materials and the names of staff who are authorized to utilize the chemicals posted on the outside door of the secure area. A Safety Data Sheet (SDS) logbook is located inside the storage area and contains an SDS for each chemical. When comparing the chemicals stored in the secure and locked cabinet with the SDS records, there were no discrepancies found. The facility administrator and the physical plant manager are the only individuals with access to the storage area.

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

The program maintains a written policy and procedures to ensure youth do not use or handle toxic, combustible, or harmful chemicals and materials. The physical plant manager maintains strict control of flammable, poisonous, and toxic items and materials stored in the program. Youth access is restricted from the zone where poisonous items are stored. An informal interview with staff revealed youth do not use, clean, or dispose of any biohazardous material, bodily fluids, or human waste. Observations during the week of the annual compliance review revealed some youth performing daily cleaning activities of sweeping and mopping the floor. The youth were monitored directly by a direct care staff member and were searched after completing each work detail. Five interviewed youth stated they have used paint. According to the facility administrator (FA) chemical, flammable, poisonous, and toxic materials are maintained in a storage room inaccessible to all staff. A review of the program's Preventive Maintenance Checklist confirmed the maintenance schedules and repairs were conducted as outlined in Florida Administrative Code.

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

The program has a written policy and procedures for disposal of flammable, toxic, caustic, and poisonous items. The program's physical plant manager is responsible for disposing unused flammable, poisonous, and toxic materials to a local household hazardous waste drop-off site, when needed. The program's disposal procedures of chemicals were created in accordance with Occupational Safety and Health Administration (OSHA) standards. The program maintains a disposal log sheet to track the disposal of such items. The physical plant manager is responsible for disposes all hazardous, such as old paint, materials paint, thinner, and stripper, when necessary, at an off-site business. There was no disposal of flammable, toxic, and poisonous materials during the annual compliance review period. An interview with the facility administrator (FA) confirmed there were no incidents of a chemical spill since the last annual compliance review.

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

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has a policy and procedures in place related to visitation, youth correspondence, mail, and use of telephone. During the program tour, the visitation schedules were found posted in the main lobby, on each youth dormitories, and master control. Informal interviews with staff and youth confirmed the program allows alternative visitation arrangements with parents/guardians. However, alternative arrangements must be approved by the facility administrator (FA). The program maintains approved telephone and visitation logs for each youth and a review of logs for the past six months validated this practice. The program has a practice of searching incoming and outgoing mail in the presence of the youth and documenting incoming and outgoing mail on a mail log. A review of the program's mail log for the past six months validated this practice. Observations of mail distributed during the annual compliance review confirmed the program's practice. Five interviewed youth stated they were provided the opportunity to communicate with their family by visitation, mail, or telephone. During the COVID-

19 pandemic, when visitation was suspended, the program allowed youth to video conference with their families through Face Time and Zoom.

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

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

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

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

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

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